Vol. XXVII. JUNE, 1932 No. 6

Recent Advances in Obstetrics

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The mother is the life of the family, the loss of whom in childbirth is a disaster. We realise that the wastage of maternal lives due to controllable causes is unnecessarily high. Maternal care should be the same the world over, whether the mother lives in the city or the country, in a palace or in a hut, she needs maternal care and nursing supervision, care and instruction during pregnancy, an aseptic delivery under the direction of a skilled obstetrician, and the same care until after she is able to resume her regular responsibilities and care for her baby. What part the nurse takes in this care differs in different communities, depending upon the available medical and nursing facilities and on the division of labour between the doctor and the nurse. The means of prevention and control of maternal, fœtal and early infant mortality and morbidity are, largely, the education of the public to expect and demand good and consecutive preconceptional, pre-natal, intra-natal and post-natal care for mothers and infants.

It is really only during the last fifteen years that any concerted effort has been made to develop, by women, a demand for antepartum care and better obstetrical service. Widespread propaganda for pre-natal instruction is doing much to better the condition of the prospective mother and give the unborn child a better chance. However, pre-natal care, no matter how thorough, is but a link in the obstetrical chain, which is broken by faulty or careless methods of delivery. Furthermore, it must be remembered that for every woman who actually loses her life in labour there are four or five whose health is permanently impaired by the effects of a difficult labour, as the method of delivery has an important bearing on maternal rates. Only consecutive and intelligent, rational obstetrics at the time of delivery, followed by post-natal observation for a period of two months after childbirth, will ever raise obstetrics to proper standards. One statistician demonstrated in a group of 5,000 mothers cared for by the Maternity Centre Association of New York during an eight-year period that the mortality was about one-third of that in the same area among other women, with a reduction in maternal rate of over 40% and of infant deaths of over 30% as compared with the control groups; in other words, that one out of every three women who die every year as the result of childbearing could be saved if they received satisfactory medical and nursing care, which means that two-thirds of these deaths are preventable. Pre-natal care, which is one of the best examples of preventative medicine that the medical profession has developed, is scarcely thirty years old. It has its greatest value in preparing the patient better to face the risk of labour and the puerperium, in reducing deaths in cases of disproportion and malposition, and in limiting the number of eclamptics. The patient should be assured of a safe delivery and should be free from anxiety and fear throughout the whole time: she knows the physician has a thorough knowledge of her physical condition and that she will not be taken by surprise at some abnormality that may occur as a result of no previous care.

Standards of Pre-natal Care

As soon as a woman suspects she is pregnant she should go to the physician for diagnosis, so that she may be under immediate supervision during the entire pregnancy. The physician at the time of the first visit should obtain a very careful history, make a complete physical examination and record all facts in a permanent history.

History: Family history of tuberculosis, insanity, hemophilia, cardio-nephritis or tumors.

Type of family labours and complications.

Past history: Previous diseases, especially scarlet fever, diphtheria, tonsillitis, rheumatism, cardio-nephritis, venereal and operations.

Previous pregnancies, miscarriages and puerperium. Weight and age of babies.

Present pregnancy: Ascertain date of last period, estimate expected confinement.

Note: Morning sickness, the menstrual molemina, vaginal discharge, bowels.

Physical Condition: Appearance.

Examination of mouth, teeth, tonsils, nose, thyroid, ears, heart, lungs, breasts, abdomen, legs for varicosities, spine, glands.

Abdomen: Presentation, position and fœtal heart.

Pelvic measurements: Type of pelvis.

Vaginal examination: Pregnancy, cervix, position of uterus, adnexa, venereal, promontary of sacrum, width of pubic arch.

Urinalysis, blood pressure, complete blood count, Wasserman, weight.

Minute instruction is given in the following points in the hygiene of pregnancy:

Diet: Should be sensible and varied.

Diet control lessens the hazard of birth injuries both to mother and child.

Salt should be entirely omitted as seasoning.

Meat is best cut down as pregnancy advances. Carbohydrates and milk, etc., are best reduced in the last two months, to restrict baby's weight.

Over-eating, especially rich foods and fats, should be avoided.

Fruits, as oranges, grapefruit, apples, prunes, aid elimination, together with eight to ten glasses of water daily.

Proteins: Lean meat, eggs, fish, milk, etc.; vegetables as peas and beans.

Carbohydrates: Milk, cereals, bread, potatoes, rice, honey, sugar.

Fats: Cream, butter, oils, fat meats, cream cheese, etc.

Minerals: For bones and teeth, calcium in milk, beans, peas, cauliflower, spinach, dandelion greens, oranges, figs.

Iron: Obtainable from beef, liver, oysters, spinach, eggs, potatoes, codfish, tomatoes, prunes, strawberries.

Vitamines: Milk and its products, cod liver oil, meat, eggs, whole wheat, cereals, vegetables, fruit.

Weight: A regular gain of two to three pounds monthly is normal.

Exercise, Rest, Bathing: Moderate accustomed exercises without causing fatigue, such as a daily walk in the sunshine or easy gardening, is best. Avoid motoring over rough roads, long railroad journeys, lifting children, elevating hands over head, scrubbing floors.

A daily afternoon nap with clothes loosened and window open is advisable.

Baths: Tepid, avoid extremes of hot or cold; showers or sponges are best in the last month of pregnancy.

Light massage is helpful.

Vaginal douche only if ordered by physician.

Bowels: Develop regularity; may take daily liquid petrolatum and bran, prunes, figs, dates, oranges if necessary but avoid strong cathartics and enemata.

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Kidneys: Are one of the most vulnerable tissues in the body during pregnancy. The urine should be examined at least every two weeks or oftener, if indicated, for albumen and sugar. A twenty-four hour amount may be saved if necessary.

Teeth: The child's withdrawing of calcium from the mother's bony tissues, together with the acid mouth secretion, causes teeth decay. The dentist should be consulted early, the teeth should be brushed morning and evening and after each meal, and the mouth rinsed with milk of magnesia. Also, give cod liver oil plus calcium.

Breasts: Should be left alone unless some emergency arises. Massage may help to develop small breasts. A breast pump or finger traction may elongate undeveloped nipples, which may be softened with olive oil or cocoa butter six weeks before delivery.

Preservation of Figure: Uplift brassieres tend to keep the breasts from sagging. Corsets, maternity or otherwise, or abdominal supports lend support and prevent undue extension. Massage with olive oil or cold cream softens the abdominal skin. Elastic stockings, worn throughout the day, support varicose veins. Proper exercise, chiefly walking, prevents stiffness.

Clothing should be sensible and hang from the shoulders. Avoid tight corsets, tight garters, which favour varicosities. High heels are bad, flat heels are proper.

Haemorrhage: In the event of a vaginal haemorrhage, the patient is advised to go immediately to bed, elevate the foot of the bed and notify the doctor. Every patient is advised to remain quiet at the time corresponding to her menstrual periods.

Maternal Impressions: The laity believe that the child may be marked because of some terrifying sight seen by the expectant mother. The fact that there is no nervous or circulatory connection between mother and child acts as a barrier for the prevention of any communication. However, profound mental emotion occasionally causes abortion or premature labour. Early attempts at interference sometimes interrupt proper blood supply to the baby's head, leading to a monstrosity or an idiot.

Routine calls to doctor's office or clinic are made regularly every two weeks, or oftener, if indicated, at which call the patient makes a verbal report covering such conditions as ptyalism, nausea, vomiting, heartburn, fainting, cramps, varicose veins, hemorrhoids, leucorrhoea, bleeding, headache, epigastric pain, edema, shortness of breath. The urine is examined, the blood pressure taken, patient is weighed, hemaglobin tested, if anemic, and abdominal palpatation examination if indicated, and routinely two weeks prior to delivery when the lack of engagement or disproportion may be evident.

The Toxemias of Pregnancy

Pernicious Vomiting: Morning sickness or nausea and vomiting is sometimes treated with a great deal of levity, being unfortunately regarded as a more or less normal sign of pregnancy. Often little sympathy or comfort is obtained until this condition becomes very serious. Neglect in this regard for a week sometimes means death to the prospective mother. Proper ante-natal instruction should prevent death here in the first three months of pregnancy.

The toxemias of pregnancy have a common factor underlying the etiological relationship between them, namely, the deficiency in the mother's carbohydrate reserve or storage of glycogen, due to extra fœtal requirements. On account of the pregnancy, the extra burden to be maintained, the body requires a well-balanced diet. However, the patient often cuts down on her carbohydrate intake and takes little fluid, sometimes with a view to reducing her weight, causing nausea and vomiting, and this may result in inanition, starvation and dehydration, which may be aggravated by an indifference due to inexperience. Per-

nicious vomiting is best treated in hospital, with isolation, rest and nursing encouragement. Often no food by mouth is given for forty-eight hours; the pure carbohydrate, glycogen, is fed in the form of glucose, intravenously, 500 to 700 c.c. of a 10% solution once or twice daily, together with nutrient sedative enemata, sedatives and daily S.S. enema. Response is generally favourable if the patient's internal organs have not been damaged too extensively. Gradually, nasal or duodenal feeding or a dry carbohydrate diet, served appealingly by the nurse, with glucose by mouth, is taken, and in a few days time, the glucose works a wonderful change, and when instituted reasonably early, saves life in this very serious complication. The husband's blood is sometimes given intramuscularly, gastric lavage may be done, gland extract given or small blood transfusions. When all measures fail, evacuation of the uterus must be resorted to.

Eclampsia

Eclampsia, mostly regarded as a preventable disease, occurs 1-500 cases and causes 26% of maternal deaths in obstetrics. Proper antenatal care with diet and regular observation should prevent this. The fits occur when the sugar in the blood is, at the time very low, showing the great glycogen or carbohydrate depletion of the mother's liver, which acts as a store house. Here also intravenous injections of glucose have a liver sparing effect, restoring glycogen to the liver and tissues, controlling the convulsions, lowering the blood pressure and stimulating diuresis.

Treatment: Prophylactic treatment in the form of pre-natal care stands out as one of the greatest contributions in the advancement of the therapy of the toxemias. It is well to assume that every pre-existing nephritic, every albuminuric or high tension case is a potential eclamptic, who should have ceaseless watching in her pre-natal period and pre-conclusive interference to prevent the convulsive toxemia.

Nursing Care: The eclamptic must be treated very gently, hardly touched at all, tongue protected, and the utmost quiet observed. The patient may be blindfolded, her ears plugged with cotton, the room kept dark and warm, and her position should be changed four to six times daily. The eclamptic is best treated by ultra conservatism, the fits must be first controlled, before any attempts at delivery are made. The convulsions may be controlled by magnesium sulphate solution, 20 c.c. of a 10% solution intravenously, immediately after the first convulsion, and repeated every hour until the fits are controlled, or by morphia gr. ¼ or ½ (hypo) and repeated after each convulsion. Other sedatives are used. When the convulsions are controlled, glucose is given intravenously, 1,000 c.c. of a 20% solution 2-4 times daily, accordingly, or by venoclysis.

Venesection may be done for blood pressure over 170, with 700 c.c. taken off.

Oxygen by inhalation is given after each convulsion.

Anaesthesia: Gas is best.

Consideration is given colonic irrigations of five gallons of 5% soda bicarbonate, hot packs and gastric lavage, leaving in 2 oz. of magnesium sulphate.

Interference: Labour should be hastened in the most conservative way possible by emptying the uterus in the safest manner, usually from below, sometimes by Cesarean section under local anaesthesia, just as soon as the convulsions are controlled.

Post-partum care is of vital importance. Once a patient has had toxemia with cardio-vascular-renal disease she should be studied most carefully between pregnancies, and in future gestations receive exceptional pre-natal care.

Other Complications

Anemia of Pregnancy: Fifty per cent. of all pregnant women have

anemia, making it imperative that obstetricians include blood counts in their routine pre-natal care. The treatment should be intensive by means of diet, iron, arsenic, together with blood transfusions, and liver in doses of ½ lb. by mouth per day or the broth extract from 1½ to 2 lbs. of liver, especially in cases of pernicious anemia during gestation.

Heart Disease: A bad heart contraindicates marriage; if married, the woman should not become pregnant, if pregnant, interruption can be considered. In severe heart cases, rapid delivery by Cesarean Section is of less strain than delivery by forceps even under a powerful narcotic. The patient should be warned pre-natally against exertion, advised absolute rest in bed with cardiac tonic if necessary, and delivered according to the decompensation.

Syphilis. Good pre-natal anti-syphilitic treatment will save upwards of 93% of babies, whereas pregnancy ends disastrously in 80% of untreated. Where the mother is treated early in pregnancy the baby is born healthy and free from the disease, otherwise a premature macerated fœtus is likely.

Goitre: If goitre is present, pregnancy should be avoided if possible. but 90% can be carried to normal delivery if properly managed. Thyroidectomy may be successfully undertaken.

Diabetes: Insulin has helped the pregnant diabetic mother greatly.

Tuberculosis: Unless the disease is quiescent for two years, tuberculous women should be advised against marriage and they should have no children. Pregnancy should be avoided in active tuberculosis, especially with any laryngeal involvement and interference if any, done in the first three months. At term the birth should be terminated as soon and as easily as possible. The mother should not nurse her baby.

Placenta Previa, of central or partial type, Cesarean Section is indicated together with blood transfusion before operation, accordingly.

Cesarean Section: The mortality in the best centres is 2.8% for clean cases, 6.2% for suspicious cases and 9% for unclean cases.

The use of high forceps is bad obstetrical technique, which has been abandoned in favour of version, Cesarean Section or craniotomy.

Abnormal Presentation: Breech or transverse presentations should be turned whenever possible. X-rays may diagnose multiple pregnancy, abnormal presentations and monstrosities.

Trichomonas Vaginalis, due to a motile parasite with flagellæ is the cause of an obstinate, foamy, purulent leucorrhoea simulating gonorrhoea. It may be treated with 1-4000 bichloride vaginal douches or variously.

Elderly Primipara: Towards forty years of age or more the necessity for Cesarean Section is increased, the woman is more likely to have fibromyomas or a fibrous uterus. Breech presentation often necessitates Cesarean Section but a test of labour may be warranted.

Sex Determination is impossible to modify. Some advocate bicarbonate of soda douches to produce males and lactic acid douches to produce females.

(Concluded in next issue)

*Lead Poisoning in Children**

By Dr. H. S. MITCHELL, Montreal, Quebec.

Lead poisoning is a subject which has received considerable attention from time to time, and one which is of medical interest not only from the standpoint of diagnosis, but also from that of etiology. As the cases which are apt to receive more prominence are those in adults, and, as lead poisoning is said to be an intoxication second in frequency only to alcoholism, it was thought that a brief presentation of two cases in young children would be of interest.

Plumbism in adults is nearly always due to occupational hazards. In children this is not so. The exposure is more subtle, the juvenile system reacts more severely to a much smaller exposure, and the manifestations of intoxication are different.

Except in rare food poisoning instances, lead is usually acquired as a manifestation of pica, that perverted appetite which leads children to indulge in ordinary repulsive objects. Occasionally the habit becomes almost a mania, and the child will go to unthought-of lengths to satisfy its perversion. Usually lead-painted chairs, toys and cribs are attacked and the amount of paint which these children can remove from a crib in the space of half an hour of diligent concentration is remarkable.

The amount of lead required to produce clinical symptoms is apparently variable and difficult to determine, but in one of our cases, viz, a two-year-old child, relapse followed a three weeks' resumption of paint eating; and in the younger case presented the total duration of lead eating was probably six to eight weeks before the cerebral symptoms developed.

The children are usually more or less irritable, but it is seldom that they complain of the colic that plays such a prominent part in the adult form. Constipation is almost invariably present but seldom noticed or remarked upon by the parents, unless they are cross-questioned. There is usually some pallor; the lead line is frequently present, but less constantly than in adults. Peripheral neuritis develops in children but there is less tendency to involve the shoulder muscles. The legs are more frequently attacked in children; most important, the cerebral manifestations are more frequent, and often abrupt in onset.

The first case is that of a girl of nine yqars who was referred as a case of poliomyelitis on account of wrist and foot-drop. There was a history of colicky abdominal pains for several weeks, obstinate constipation, and during the two weeks previous to admission, tenderness in the muscles, with increasing muscular weakness. There had been no muscular cramps in the extremities. She stumbled when she walked, and could not use her hands properly to feed herself. On admission the striking thing was bilateral foot-drop and wrist-drop. The peronei, extensors of toes, and tibialis anticus were paralysed. The extensors of the hands on both sides were paralysed but the supinator longus was active. It is uncommon except in children, to see paralysis of the tibialis anticus. The mucous membranes were pale, the skin was pallid, and there was a very definite lead line on the gums. There were no cerebral symptoms, no optic neuritis and no neck stiffness nor head retraction.

Blood Examination: Red blood cells, 3.7 millions; white blood cells, 7,200; hæmoglobin, 73 per cent.

Bloodsmears showed 3-4 stippled red cells in every field.

It was noted at the time that the hæmoglobin was actually much high-

(*From the Medical Department, Children's Memorial Hospital, Montreal. Read before the Montreal Medico-Chirurgical Society, January 22, 1932.)

er than it might have been estimated. The pallor of lead poisoning is a striking feature and said to be due to vaso-constriction of the skin vessels. Spinal puncture showed clear fluid under pressure of 150 mm. water, and seven cells per mm. (lymphocytes).

She was given calcium lactate by mouth, high calcium diet, and the feet and hands were put in cock-up splints. Later massage was instituted. In six weeks definite recovery was in evidence and now (three months) she has almost complete return of function in the hands. The feet, as is usual, are slower in recovering.

Urine: Chemical analysis revealed the presence of lead in small quantities.

The second case is a female child of three years. She was referred to the hospital in generalised convulsions of sudden onset, following a short period of a couple of weeks of general ill health, marked constipation, irritability and projectile vomiting. During the last 36-48 hours she had developed a squint. This led the family physician to strongly suspect tuberculous meningitis; also she was quite pale and the question of a co-existing blood dyscrasia was raised.

On admission the child was semi-conscious, and when undisturbed lay on her side, head retracted, in a stuporous condition. Although there had been several convulsions during the day, none followed admission to hospital, in spite of the absence of immediate institution of specific treatment. There was marked pallor of the mucous membranes. There was a strabismus, definite neck stiffness and questionable bilateral Kernig's sign. Bilateral papillœdema was present. The knee jerks, ankle jerks and biceps tendon reflex were all present and slightly exaggerated. The abdominal reflexes were present. There was no Babinski. There was no paralysis of any muscles of the extremities. The only muscle paralysed was the lateral rectus of the left eye. Examination of the heart and lungs was negative. The lymph glands were not palpable. The bowel contained large palpable fecal masses. The liver and spleen were not palpable.

Blood Examination: Red blood cells, 3.4 million; white blood cells, 22,100; hæmoglobin, 50 per cent.

A stained film showed anisocytosis, large numbers of stippled red cells, occasional normoblasts, and occasional myelocytes.

Lumbar Puncture: Clear fluid, pressure 170 mm. water, cells 200 per c.mm., all lymphocytes. Pandy's test for globulin was strongly positive. No organisms were found on smear or culture (including search for acid fast organisms). The spinal fluid contained 154 mgms total protein per 100 c.c. but did not give a positive test for lead.

An intradermal injection of O.T. 1 in 1000, 1/10 c.c. was negative. In the meantime a faint but definite lead line was discovered on the gums. An x-ray taken, looking for possible calcified abdominal lymph glands showed none, but characteristic findings of plumbism at the ends of the ribs. X-rays of the epiphyses at the wrist revealed the same thing.

On questioning the parents, the source of the lead was found to be in eating furniture paint.

Improvement was continuous and rapid following interruption of the paint-eating, the administration of a high-calcium diet, calcium lactate by mouth and calcium gluconate intramuscularly. De-leading was later carried out by administration of ammonium chloride and a low calcium diet.

This case demonstrates that lead poisoning should always be borne in mind as a possible cause of convulsions of obscure origin.

The question of renal impairment is frequently raised in connection with lead poisoning. The younger child has not been investigated along this line, but the older child shows

no evidence of disturbance by the Mosenthal test, although her urea concentration factor is lower than normal. She has no albuminuria.

In the last few years a further impetus to the study of plumbism was given by Vogt, Park, and others who described special changes in the ends of growing bones in cases of lead poisoning. In several proven cases of lead poisoning it was found that there was a broad dense area in the x-ray picture at the ends of the long bones.

Specimens from autopsy material which have been studied showed that there was four times as much lead in the dense areas as farther back in the shaft of the bone. It was also demonstrated by Park that, in microscopical sections of the specimens in plumbism, the trabeculae are much more compact in these radiologically dense areas. Therefore, whether the radiological appearance is due to one or both causes is not yet definitely proven.

Dense lines are found at the ends of growing bones in several conditions, notably healing rickets, scurvy and congenital syphilis. But as this is associated with other characteristic signs, there should be no confusion. The rare condition of marblebone should be borne in mind.

It is not claimed that these x-ray findings are characteristic of plumbism alone, as there is good reason to believe that other heavy metals such as bismuth or arsenic may produce similar effects. And it has been known for many years that phosphorus produces a somewhat similar picture. Nevertheless, the discovery of such an x-ray appearance should raise the question of lead poisoning, especially in an otherwise normal bone; and its demonstration in a suspicious case may be regarded as confirmatory evidence.

Treatment: For many years in addition to magnesium sulphate by mouth, and general dietetic and hygienic supervision, the most used drug was potassium iodide. Later sodium thiosulphate was introduced. Both these preparations very definitely increase the elimination of lead. But in the neurological crises, where there is already too much lead in the circulation it is obviously desirable to remove it rapidly. As shown by Aub, Minot, Fairhall and Petznikoff, the administration of a high calcium diet, augmented by calcium lactate by mouth, or calcium chloride intravenously, rapidly removes the lead from the circulation and concentrates it in the bones. By this means the acute phase of the intoxication is easily controlled. Later on, when the acute symptoms have subsided, elimination may be proceeded with. This is accomplished by altering the hydrogen-ion concentration of the blood, either by administration of acid or alkali; the same workers have shown that the combination of an acid salt (ammonium chloride) with a low calcium diet gives the best results.

It is sometimes argued that if the lead can be satisfactorily stored in the bones, it should be left there, and the patient kept on a high-calcium diet or in a so-called positive calcium balance. But as it has been so clearly shown experimentally, in addition to the clinical knowledge, that an acidosis may suddenly release into the circulation large quantities of lead, this temporising may have serious results. In carefully controlled adults theoretically such a stand may be justifiable, but the frequency of acidosis in children, occurring either independently or in association with their many infections, leads one to feel that it is wiser to proceed with elimination of the lead in a quiescent interval, than to run repeated risks of acute saturnism.

A Case Study in Lead Poisoning in a Child

By SYLVIA FISK, Student Nurse, Children's Memorial Hospital, Montreal, Quebec.

Ameline, aged nine years, was admitted to the Children's Memorial Hospital on November 4th, 1931.

Complaints on Admission: (1) Weakness of arms and legs for one week; (2) Loss of appetite, one week; (3) Pain in abdomen, two weeks; (4) Pain in the limbs, three weeks.

Previous Medical History: Her mother stated that she had never been very healthy. She had "colic" many times as a baby, also measles, scarlet fever and pneumonia. Two years ago a tonsillectomy and adenoidectomy was done.

Family History: Her father and mother are thirty-one and thirty years old, respectively, and are living at home apparently healthy. There is one other child, a little boy, one and one-half years old, who is also well. There is no history of tuberculosis, syphilis, rheumatic fever or cardio-renal disease in the family.

History of Present Condition: About the middle of October Ameline complained of pains in the arms and legs. She had a peculiar manner of walking which her mother noticed. She complained of tiredness and showed a desire to stay in bed. Her appetite was poor. She was very constipated. The weakness in her arms and legs grew worse and her mother took her to the out-patient department where admission was advised.

Social History: Ameline was living at her home in a congested area of the city previous to her admission to this hospital. It is in a very poor district and the surroundings are most undesirable. Her father has been without work for some time and the family is in straitened circumstances. When at home Ameline says she sleeps in a small room by herself. They are French-Canadians and speak little English.

The parents seem very fond of their daughter and bring her such playthings as they can afford when they visit her. Ameline says she has been attending school, and is bright and alert for her age.

Physical Examination: The child appeared well-developed and well-nourished. The mucous membranes were all rather pale and the skin was also rather pallid. The striking feature, however, was bilateral foot-drop and wrist-drop. Examination of the heart and lungs was negative. No abdominal organs could be palpated. The superficial lymph glands were not enlarged. Examination of the nose and throat was negative. There was, however, a very definite blue line at the margin of the gums, and she had several carious teeth. The neck was not rigid and there was no Kernig's sign. There were no pathological reflexes. Examination of the fundi showed no abnormalities, the reflexes were normal.

Laboratory Examinations:

1. Blood Count: Red blood cells, 3,700,000 per c. mm.; white blood cells, 7,200 per c. mm.; hæmoglobin, 73 per cent. Showing secondary anaemia.

2. Blood smear showed stippled red blood cells, which is an important diagnostic sign.

3. Urinalysis: This contained no sugar or albumen. A chemical examination revealed the presence of lead in small quantities.

4. Lumbar Puncture was done on admission. About five cc. of clear fluid were withdrawn under normal pressure. The cell count was five per c. mm. There was no increase in globulin.

5. X-ray revealed a dense white line at the epiphyses of the bones.

Diagnosis: The wrist and foot-drop pointed to a peripheral neuritis and the discovery of lead in the urine with the stippled cells in the blood, secondary anaemia and x-ray find-

ings seemed to indicate that the case was one of chronic lead poisoning.

Treatment: The patient was given a high calcium diet, and calcium lactate gr. x, t.i.d., p.c. Laxative in the form of magnesium sulphate dr. ii was given once a day.

Plaster of Paris splints were applied to the arms and legs. Massage was given. When the acute stage is passed this is to be followed by ammonium chloride in large doses and a low calcium diet.

Convalescence: Ameline is now convalescing. Her wrists are nearly normal. The feet are usually slower in recovering. She has almost complete use of her hands. There is no tenderness in the muscles now.

Since admission Ameline has gained six pounds in weight. She is now approximately the average weight for a child of her age and height. Her colour is much improved.

She is bright and talkative, easily amused and obedient. She understands English and can speak a few words.

Diet: Ameline was put on a high calcium diet. Milk is given freely as this is very high in calcium. Milk products, legumes, cauliflower, fruits, eggs, and some other vegetables are given her along with sufficient other food to make up a well-balanced diet. Her meals are served attractively and Ameline has a fairly good appetite.

At first she was unable to feed herself but since the improvement in the muscles of her arms the splints are removed at mealtimes and she is allowed to feed herself.

Nursing Care: Ameline has a bedbath each day. Her heels and back are given special care as these are apt to become reddened and sore. They are well rubbed with alcohol and powder, applied at least twice during the day. The splints are padded with rolled wool. Her arms and legs were carefully handled because of the tenderness of the muscles. This has subsided now, and she is not complaining.

Ameline brushes her teeth each morning. In the afternoon she has her face and hands washed and her teeth cleaned again. Her bed linen is changed as often as necessary.

On admission Ameline had pediculi. Oil of sassafras was well rubbed into the scalp and her hair enclosed in a capeline. The next morning her hair was thoroughly washed. Tincture of quassia was applied to remove the nits. Each morning her hair is fine-combed, a solution of two per cent. Lysol being at hand, in which to place the comb.

The constipation and irregularity of bowel movements were corrected by the laxative.

If the weather is suitable Ameline is wrapped up warmly and is put out on the gallery each morning. This she enjoys very much.

New Points Learned:

1. The causes, symptoms and treatment of lead poisoning.
2. The difference between lead poisoning in adults and children.
3. The importance of x-rays in diagnosis.
4. Foodstuffs rich in calcium, and the part diet takes in treatment of disease.
5. The importance of caring for the skin beneath splints.

References Read:

1. Osler's Principles and Practice of Medicine: McCrae; Section iii; Lead Poisoning.
2. Cushny's Pharmacology and Therapeutics: Edmund and Gunn; Part iii; Heavy Metals and Metalloids; Lead.
3. Materia Medica: Blumgarten; Page 78.
4. Materia Medica: Dock; Pages 218-220.
5. Diseases of Children: McComb; Pages 248-253.
6. Practical Dietetics: Pattee; Page 793.
7. Elementary Household Chemistry: Snell; Pages 193, 211-217.

Discussion of Lead Poisoning:

The blue line on the gums is a valuable indication of lead poisoning, although it may not be present if the mouth is kept clean and in good condition. The lead is absorbed and con-

verted into a black sulphide by the action of sulphuretted hydrogen.

The wrist and foot-drop that is present in lead poisoning is really a form of paralysis. The cause of this paralysis is a peripheral neuritis and degeneration of the nerves. The fingers first become flexed, later, the wrist. This remains, so simulating wrist-drop. The muscles most used are first affected. The splints were applied for the purpose of immobilisation, to avoid any additional strain on the muscles and to correct the foot and wrist-drop.

Lead may gain entrance to the body through the lungs, digestive organs, or skin. It is carried in the body as a phosphate and is stored in the bones. An excess of calcium favours the harmless storage of lead in the body so during the acute stage calcium is given freely in the diet and in the form of medication to try and hold the lead in the bones. It is stored in the bones and shows up in x-ray by the dense white line appearing in the epiphyses. This phenomenon may occur in other diseases as scurvy and rickets, but as it was accompanied by other symptoms no doubt was felt as to the diagnosis.

Although lead appears to be absorbed rapidly into the body it is excreted slowly. It is chiefly eliminated by the gastro-intestinal tract. For this reason the laxative was given.

Lead is found in most tissues in the body but it particularly affects the kidneys. For this reason urinalysis was made frequently and albuminuria fearfully watched for.

The purpose of the low calcium diet will be to remove the lead from the bones. The ammonium chloride hastens the elimination.

In adults, lead poisoning appears as an occupational disease usually being chronic in form, thus differing from children in whom the cause of the disease is accidental.

"Lead colic" is a more pronounced feature in adults than children.

Lead poisoning usually occurs without fever. Throughout the patient's course in the hospital her temperature did not vary very much.

On the Old Fort St. John Trail

By MARY ELLIS CONLIN, Nursing Branch, Department of Health, Alberta.

Old timers seeking their fortune in furs or gold have travelled this winding trail for many a year, but it is only within the last two or three years that some twenty-two hundred people have chosen this land to set up home making. Many of these people come from the dried-out areas of Saskatchewan and Southern Alberta, where the farmer had not seen a crop, nor the horse green pastures and running streams for several years. Imagine what an Eldorado even muskeg country would seem to them. Trees! Trees! Shelter for man and beast, to say nothing of firewood right at their front door. And water! plenty of it. It does not matter if one must carry an axe to make a new trail where the old rut has worn too deep, or if one becomes bogged returning from town some 62 miles away. These are surmountable barriers compared to the hopelessness of tilling land which refuses to yield a harvest for their labour. "Open Air Camps" are visible all along the trail. At one of these spots we picnicked, the driver and her companion, brought along to help us out if we should get stuck. We did need him too. Trying to drive through several feet of freshly turned-up muskeg requires considerable "push and pull."

The Alberta Government has its big caterpillar road machine working, building a new highway through the country where these homesteaders are located. Not that old Peter Grenier wants it. When questioned by one of us as to whether he was content to see this new highway go in, he remarked: "Oh, we do not want a highway, just give us a trail good enough to get to town once a year, that is all we need." This is the sort of fellow who will go still farther north, when civilisation moves up to his door.

It is right here that the Honourable Mr. Hoadley, Minister of Health for Alberta, saw fit to place a district nurse. A meeting was called on three days' notice to organise a district and old and young attended. Such enthusiasm! A group of four husky young men volunteered to commence the cellar the very next day. Another group agreed to go into the heavy timber and haul logs, still another group promised their time to build the house, and lastly, two efficient carpenters, present at the meeting, agreed to finish it up so that a nurse could be sent in three weeks later. Tragedies in several families occurring during the last year, owing to the lack of medical help, the nearest doctor being 62 miles, and the nearest railway station and telegraph office some 50 miles, caused these new settlers to be so energetic in doing their share towards obtaining the services of a nurse.

Promptly at the end of three weeks, a letter was sent to the Department of Health announcing that there would be a dance given in the nurse's cabin on a certain date, and asking that the nurse be sent in in time to be present so that she might meet the people. What a scrutiny she will be subjected to, but she has nothing to fear for these people need her, and she is well equipped in training and experience to take care of them.

She will have some difficult travelling in all sorts of conveyances. In the springtime when the water comes down from Clear Hills, four miles distant, she is likely to be seen on horseback most of the time, but it is a new district, and that means the opportunity of putting her stamp on good work done, and a new field properly organised—there's always a thrill when you are the one that is doing it.

Most of the furniture will be built on the spot, as freighting over the trail is a wearisome and expensive job, but a comfortable chair, bed and blankets are being sent in to insure rest when weary days are done. A well filled medicine chest in a tidy dispensary will always be ready to serve the people's needs, and one more district will be grateful for insuring the care of mothers and babies and administering first aid to the male population by placing a well-trained and experienced nurse at their disposal.

The Benefit of Psychology to the Nurse and Doctor

By S. MARGARET JAMIESON, Superintendent, Brampton Hospital, Brampton, Ontario

Records of abnormal mental phenomena reach back to the dawn of history and can be found in the oldest books of both Eastern and Western worlds.

In the Old Testament, one reads of Saul's peculiar mental conditions at various times, and also of the behaviour of Nebuchadnezzar.

We find Ulysses simulating madness to justify his abstention from the Trojan War, and David assuming madness to escape from Achish, King of Gath.

The general conception of this condition, at that time, was that the afflicted person was possessed by a demon. With the coming of Hippocrates, treating insanity as a disease of the brain made some headway in Greece, but the Dark Ages temporarily obscured the light and the old idea of demon-possession held sway. Witchcraft was but another phase, and history gives us many vivid pictures of the various means employed through the ages to stamp out this condition.

The phase of demon possession passed and one where the mentally ill were segregated in dungeons was ushered in. Terrible was the misery and suffering of these people. The first alleviation of their misery was started in England, and, shortly after, work along the same line was started in France.

What is vaguely called insanity is really a wide range of greatly differing conditions and diseases, all playing havoc with our organ of conduct and behaviour and its functions.

The imbecile, the hysterical, the epileptic, the insane and the criminal were formerly regarded, sometimes as saints or prophets, sometimes as wizards or witches, often as the victim of demoniac possession; on the one hand to be revered and worshipped, or on the other to be burned or otherwise tortured.

Until very recent years, the mental aspect of nursing care has been almost entirely neglected, to the great detriment of nurse and patient in particular, and in general, to the world at large.

The nurse meets the mental and nervous element in every case of physical disease or injury with which she comes in contact, but never having been taught to recognise this element, its significance escapes her. Her failure to recognise this element should not be called carelessness, because the nurse has not been taught and trained to observe the symptoms. Due to the nurse's almost entire lack of knowledge of the primary obscure symptoms of insanity, many cases under her care have become permanently insane who might otherwise have been saved or helped. Again through her lack of understanding, the malady may be aggravated by the nurse's endeavour to argue about the delusion and convince her patient of the fallacy of his idea. Watching symptoms and finding causes for them is very important. The nurse has many opportunities for observation which the doctor has not. Some training in mental work gives a nurse an entirely different viewpoint.

Most people think that real mental patients are disturbed or distressed all the time, not realising that at times they are quite normal. They do not realise that often these patients are not so different from those of us who are well and that each patient must be treated as an individual and that groups can never be treated collectively.

It is only within the last fifty years, or perhaps sixty, that there has been any clear recognition of the vast importance of the mental factor in the

production and treatment of disease. Professor Thorndike has stated that any person with a temperature of 100° F. cannot be counted mentally normal. If this statement be true, and there seems to be no reason to doubt it, one at once sees the necessity and great importance of the nurse and doctor having, at least, a working knowledge of the truths and principles of psychology as applied to their particular work in preventing and curing or alleviating mental and physical illness.

The first psychological laboratory was created in Leipzig, Germany, in 1878. Since then, psychology has progressed slowly but surely until at the present day practically all worth while universities have laboratories in charge of men who are making a name for themselves and their university in the work they are doing in research and practical application of the truths they have discovered.

In the medical profession, especially among French-speaking people, there first came into existence a definite system of psycho-therapeutics, in which suggestion and other agencies were assigned their rôles, and principles were laid down to indicate the scope of these agencies and the means of turning them to best advantage. Three main agencies which are utilised by the practitioners of this branch of medicine, are those of self-knowledge, self-reliance and suggestion.

The graduate nurse from the general hospital is not well equipped to care for the functional nervous diseases. Therefore, special training for those who elect this work is sadly needed.

If the nurse is to be more than a glorified lady's maid, rendering her patient more and more dependent as a result of her ministrations, she must learn how to lift the patient out of the old involved life, into a new and more wholesome atmosphere. There is nothing in modern medicine which seems more promising for humanity than a system which may so calm and steady the tortured mind that material opportunity may at least be successfully grasped and that spiritual truth may eventually be understood. There is no clearer sign of medical progress than the present rapid adoption of the principles of the work cure in the sanatoria and mental hospitals of the world.

In the general hospital wards associated with physical illness, we see delirium, depression, excitement, neurasthenia, psychasthenia, paranoia, deterioration and other psychoses; in fact, almost all conditions, more or less defined, which one finds in the special or mental hospital.

The general hospital physician or nurse seldom recognises these conditions and they are left uncared for. The patient is fed, bathed and given the treatment and medication prescribed, but no time is taken to inquire into the reason why he is cross or irritable, why he weeps or laughs, etc. He is frequently described as selfish, ungovernable, intolerable, impatient, and no effort is made to understand the why and wherefore.

Prevention is the watch-word in mental work and to the well-equipped nurse is given the opportunity. But one cannot do preventive work if one does not know what should be prevented, nor can one observe without a knowledge of what to observe, and the mental and physical life are so closely related that one cannot consider the one without the other.

It is important that the study of the phenomena of mental disease should be made obligatory on medical students and nurses. Such disorders are encountered daily in the routine of general medical practice or of nursing. How few there are who are able to discriminate between a toxic delirium due to an infection, a fever, a poisoning by iodoform or some apparently harmless remedy used in medicine or surgery, etc., and a well developed form of mental disease requiring close study and watchful care.

And yet the future of the patient may be permanently affected for weal or woe by the prompt recognition of the condition.

The nursing care of mental disease can never be adequately accomplished until it is placed in the hands of educated women who are trained for it and are familiar with general nursing, but who have secured an insight into the higher privileges of the nurse, which are acquired only by actual contact with mental cases.

The only real test of health is its serviceableness to the needs of life. We have an unhealthy state of the personality before us wherever the equilibrium of the human functions is disturbed in a way which diminishes the chances of existence, and the seriousness of the ailment depends upon the degree of this diminishing power. Seen from a strictly psychological viewpoint, we must expect a broad borderland region between the entirely normal, well-balanced life and that unbalanced disorder of functions which really interferes with the chance for self-protection and effectiveness.

The conduct of the insane is usually anti-social and it is this criterion which usually determines whether or not the patient is confined to a mental hospital or not. Also dissociation has been carried to a degree incompatible with normal thought and behaviour, and the mental processes are allowed to pursue their course quite undisturbed by the contradictions presented by the facts of experience.

In hereditary insanity, the probability of transmission depends, as well as the severity of the disease, upon the severity of the disease or degeneration in the parents.

Mental disease is described as a marked failure of adjustment to one's surroundings. Mental hygiene must deal, therefore, not only with intellect, but with conduct; and the child must be developed so as to think clearly and to live harmoniously with others in his little world. Habits of mind must be formed with at least as great care as are table manners and social grace. Each of us is a compound of tendencies inherited from a variety of ancestors, and while a child of recognised neurotic inheritance requires more careful mental guidance, all should be prevented from developing unhealthy habits of thought and conduct. Lack of self-control is an outstanding feature of many mentally unbalanced people. Parents should teach and preach the doctrine of substitution for the unattainable, with consequent peace of mind.

By a campaign for mental hygiene is meant a continuous effort directed toward conserving and improving the minds of the people; in other words, a systematic attempt to secure human brains so naturally endowed and so nurtured that people will think better, feel better and act better than they do now. Such a campaign was not to be expected before the use of modern medicine. For, only with this have we come to look upon states of mind as directly related to states of brain, to view insanity as disordered brain-function and to recognise in imbecility and in crime the evidence of brain defect. Now such unfortunates are looked upon as patients with disordered or defective nervous systems, proper subjects of medical care; some of them are curable; some are incurable, but still capable of being educated to social usefulness; a part of them are socially so worthless, harmful or dangerous as to make their exclusion from general society necessary. It is but a short step from such a reformation of ideas to the realisation that less marked deviations from normal thought, feeling or behaviour are also evidences, either of brains defective from the start or made abnormal in function by bad surroundings or by bodily disease.

Modern medicine has taught us to recognise that the conditions necessary for a good mind include: first, the inheritance of such germ-plasm

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from one's progenitors as will yield a brain capable of a high grade of development to individual and social usefulness; second, the protection of that brain from injury and the submission of it to influences favourable to the development of its powers. If these doctrines of modern medicine be true, the general problems of mental hygiene become obvious. Broadly conceived, they consist in providing for the birth of children endowed with good brains, denying as far as possible the privileges of parenthood to the manifestly unfit, who are almost certain to transmit bad nervous systems to their offspring, and also in supplying all individuals, whether ancestrally well begun or not, with the environment best suited for the welfare of their mentality.

Mental hygiene of a prophylactic nature falls into two classes: group preventive mental hygiene and individual preventive hygiene. The latter requires very special work. In looking at a child and frequently an adult, one is conscious that his only chance of having a useful and happy life is through teaching him to overcome and replace certain accustomed ways of thinking and feeling.

Thought and emotion are both instigators to action. Emotion both in the child and the adult is largely the motivation or driving force as regards action. Some emotions, for instance, fear and rage, appear in the earliest days of infancy. If these emotions are not properly trained and educated they may bring disastrous results on the individual and the community.

Training should be directed early to narrowing the expression of the unhealthy emotions and to broadening the capacity for happy and wholesome feelings. Jealousy must be rooted out, suspicion destroyed, the habit of depression and anxiety must be combatted by habitually smiling and taking a courageous attitude toward life.

Moods on which young people sometimes pride themselves should be discouraged, since they may be the starting points of nervous difficulties, not to say of insanity.

Among all the predisposing causes of nervousness, the first place must be assigned to drunkenness. No other source of mental and nervous disease can be pointed to with anything like the same certainty. Alcoholic poisoning is believed by many eminent physiologists to infect the reproductive germs, in opposition to Weisman's theory, which certainly finds no support in the history of nervous disease. It is certain that the posterity of drunkards suffers to an almost incredible extent from the milder and from the severer forms of mental and nervous disease. For this reason, the great neurologists, Foil, Mobeus and Weir Mitchell, have been great advocates of temperance. Nervousness is regarded peculiarly as a disease of girls and women, but a nervous system which requires frequent alcoholic stimulation in order to function is certainly diseased.

It would seem almost superfluous to emphasize the extreme injury that idleness produces. We know that an idle child usually becomes mischievous and incorrigible, and that adults without occupation of some kind will sooner or later develop habits and ways of thinking harmful to themselves and others. The same condition that is so pernicious, that a normal person cannot withstand its fatal blight, can hardly be other than deplorable for those already impaired. Idleness is a fictitious term in reference to mental activity, for if it cannot function normally, it will function abnormally.

Psychology has made possible the modern advance in the study and intelligent treatment of mental processes and actions, both in those called mentally ill or mentally normal. The causal view only is the view of psychology, the purposive view lying outside it.

Every psychical fact is to be thought of as an accompaniment of a physical process, and the necessary connections of these physical processes determine, then, the connections of the mental facts.

In psychomedical problems everything belongs which allows the application of causal psychology in the interests of health.

Physiotherapy attempts to cure the sick by influencing the body, perhaps with drugs, medicines, electricity, baths or diet. Lady Macbeth was treated thus, without success, as with her it was the mind which was diseased. In opposition to physiotherapy is that of psychotherapy, which is the practice of treating the sick by influencing the mental life. Psychiatry is the treatment of mental diseases only. In psychotherapy one must not be content with merely giving advice based on well-established psychological principles, but must give the patient something to do, something which will make him an active participator in bringing about his cure.

Re-education of thought and will, so that a better adjustment may be made, can often be brought about by the nurse, who, in homes, gains a better insight into many undesirable factors which the doctor never would in his few moments while visiting the patient. Through the training of thoughts and feelings, there is a continuous effort to lead the patient outside the narrow walls of self into the life of the community. Most of the "nervous" and insane patients are out of harmony with their environment. It is social maladjustment. To get them into a larger life—to make them feel themselves a part of the striving, courageous world—is to lead them away from dangerous introspection. Most of these "nervous" patients muddle along through painless days, their lives a patchwork of ill-matched activities, miscellaneous, heterogenous—leading nowhere, save to a nervous breakdown.

A few methods of applying therapy, most of which it is possible for a nurse to use in greater or lesser degree, are enumerated:

Environment Therapy does not mean a change of scene only, or geting away from irritating surroundings, but the bringing in of new surroundings where imitation may have an opportunity to act in a health-restoring way.

Amusement Therapy is far more needed today than is realised. In the nursing field, and also among young working women and poor children, this opens up a very wide field for work of which the value has not yet been estimated.

Occupation and Work Therapy—The kind of work given is important as each kind of employment has an intellectual influence. But occupation therapy may not be satisfactory, as it may allow certain minds too much time to surrender themselves to unhealthy imaginings. In these cases, work therapy would be found useful. It may remove financial worries, but will, as well, take the attention and interest away from the field giving rise to the mental disturbance. Enforced work therapy may seem drastic in some cases, but the fact remains that it is often the only kind of psychotherapy available.

Isolation Therapy is too little used. By this is meant the keeping of a "quiet hour."

Electrotherapy is a newly developing field which gives a nurse large opportunities. Due to her knowledge of anatomy, physiology and chemistry, she has a good foundation to start on, and later can apply it intelligently and effectively, after being specially trained in the technique and theory of electrotherapy.

Music Therapy can be frequently used with good effect. This was used in Old Testament times, as we learn from the life of King Saul.

Physical exercises frequently possess valuable therapeutic powers, perhaps most useful with those not in the habit of developing the physical.

Many and varied must be the motives supplied in order to induce the majority of the mentally ill to do work of any kind. In furnishing motives, we must bear constantly in mind that our patients are deprived of the ordinary stimuli of life. The stimulus of necessity is taken away as well as that of ambition, competition, love of adventure and of expressing affection for dear ones by working for them.

The tangible results of occupation methods, while difficult to estimate in the laboratory sense of estimation, are sufficiently evident to be convincing. Large numbers of chronic patients can be re-educated to some degree of usefulness and to a greater degree of contentment; occasionally buried talents are discovered which are surprising.

In our public schools, a place for the application of psychological truths is slowly being made. Today, in many schools, mental tests of different types are being used to grade the ability and the progress of the pupils. Through these means systematic grading of pupils can be obtained, with better results both for the genius or those mentally deficient, as each will be, or can be, placed in his or her proper niche and taught and treated as they severally require. If it is impossible to have a psychologist do this work, it is quite possible for the teacher with some training in the method of using these tests, to grade her pupils by many of these tests, or the school nurse may do so—if she has time.

In our colleges, the principles of psychology might well be more generally applied, for the benefit of the students. If this were done in our schools and colleges, those in need of special care or treatment might receive it, resulting in many averted tragedies and much good to all.

The law courts of today are finding that psychology explains many a puzzle and aids in giving judgment in many cases, for it is becoming more recognised every day, that a great part of the criminal world is composed of people who should be segregated, but who are capable of earning their living under proper supervision. If left at large they are a menace to humanity and breakers of law and order.

The hospital training school for nurses is an important field, much neglected, where mental tests could be used to great advantages. So many misfits from all other educational fields are deposited on the training school doorstep, that such a protection, especially to the sick, is a vital necessity. It would avert many a personal tragedy, many mistakes, misunderstandings, and provide a much higher type of woman for our future nurses. Incidentally, might such a sorting out process not have a salutary effects on the present situation of apparent unemployment among graduate nurses?

If radio's slim fingers can pluck a melody
From night—and toss it over a continent or sea;
If the petalled white notes of a violin
Are blown across the mountains or the city's din;
If songs, like crimson roses, are culled from the thin blue air
Why should mortals wonder if God hears prayer?

—Ethel Romig Fuller.

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History of the Saint John River

By FRED. H. PHILLIPS, Saint John, N.B.

The Rhine of America—perhaps this appellation is almost as old as the name given to the river by Samuel de Champlain on St. John the Baptiste's Day, June 24, 1604. Built on seven hills clustered about the mouth of the river stands the Loyalist city which shares the name of the mighty flood whose waters tumble into the Bay of Fundy over the Reversing Falls.

Impassive as a sphinx, unchanging as the stars which have mirrored themselves upon its surface since the first night followed the first day, the mighty river has flowed, unheeding the changing scenes of human struggle which have unfolded themselves upon its shores. The exact date of the first appearance of the white man in the harbour is not known, but as early as the opening of the sixteenth century hardy Basque, Breton and Norman fishermen had ventured into the Bay of Fundy. Finding the Indians friendly and willing to barter their furs for the merest trinkets, the fishers made further visits and during this century the trade with the Indians grew to quite appreciable proportions.

Entering the harbour, Samuel de Champlain and the Sieur de Monts, by giving the river the name of the Saint, commenced the first authentic history of the Saint John river. Three disastrous winters discouraged their hope of colonisation and friendly savages watched the two little vessels disappear over the eastern horizon, only to reappear three years later when Poutrincourt, with renewed zeal for adventure, returned to Port Royal.

Meanwhile the traders of St. Malo and Rochelle established themselves on the island, Emenenic, the Long Beach of the Saint John, and these having shown disregard of Poutrincourt's monopoly, Biencourt, son of Poutrincourt, decided to exact their submission, but returned to Port Royal after having established the best of feelings with Captain Merveille, commandant of the island settlement. Following the capture of Port Royal, for the English in 1613, Acadia was not restored to France until 1632, by the Treaty of St. Germain.

The sack of Port Royal in 1613 had driven young Charles la Tour to a life among the Indians and only his diplomacy saved him from spending his days as a savage. During the war between England and France, 1627-29, he obtained from Louis XIII a commission as lieutenant-general and at the same time he secured from Sir Wm. Alexander the title of baronet of Nova Scotia. Having obtained a grant on the lower Saint John he erected and fortified his headquarters on the harbour at the river mouth. In 1635, d'Aunay Charnisay, having been placed in command of Acadia following the Treaty, and La Tour, found that through bungling on the part of the government in France, their respective territories were defined so that each included the stronghold of the other, a situation not likely to augur well for peace betwixt two men, both of whom were possessed of more ambition than forbearance. Charnisay repaired to France where he secured five vessels and the service of five hundred soldiers. Meanwhile La Tour was not idle—through personal accumulation of an armed vessel, ammunition, supplies and one hundred and fifty soldiers together with aid from Boston, he was able to recapture Port Royal and relieve his own fortress. Charnisay was determined—his frequent attacks resulting finally in the capture of the Fort and death of Lady la Tour, while its commander was absent. When, in 1651, La Tour, returning to those scenes from which he had been twice exiled, and finding himself re-instated in Saint John as lieutenant-

general of Acadia, has shown himself to have been more the realist than the romaticist. He swiftly solved a dispute concerning claims of Charnisay's widow (Charnisay having been drowned shortly after the capture of Fort la Tour) by marrying her. A year later, when ships commanded by New Englanders from Massachusetts and supplied by Oliver Cromwell, faced the garrison, La Tour surrendered his fort—but not his claims. Being a clever diplomat, by placing his claims before Cromwell, La Tour succeeded in obtaining, with two others, Thomas Temple and William Crowne, a grant for nearly all Acadia, after which he sold his rights and retired to private life. He died in 1663, and his ashes rest in the soil of his loved Acadia.

Perhaps readers of this narrative whose words do poor justice to its theme will condemn and say that this has not been a history of a mighty river but only that of a few men who touched its shores. Rather it exemplifies upon its eternal surface the essence of all history. Ever the ripples rise and fall, surge and break, but even in that rise and fall, in that ceaseless change which yet changes not, consist the eternal sameness which only the river understands.

Miss Edna M. Auger

By the death of Edna Mabel Auger the nursing profession has lost one of those most active in nursing education, especially in its development in the province of Alberta.

Miss Auger died at the Medicine Hat General Hospital on May 2nd, following an attack of pneumonia, with complications.

Daughter of a family of Western pioneers and graduate of the School of Nursing, Medicine Hat General Hospital, 1906, where most of her years since then have been spent, Miss Auger was chosen by the nurses of Alberta to represent that province when the History of Nursing Society of the School for Graduate Nurses, McGill University, published the historical pamphlet, Pioneers of Nursing in Canada.

Awarded the gold medal of her year, she became charge nurse in the operating room previous to going to New York, where three years were spent in the operating room at Dr. Bull's private hospital. While in New York, Miss Auger studied dietetics at Teachers College, Columbia University. Called back to Medicine Hat, she became assistant superintendent and instructor of nurses. This work was interrupted when she resigned in 1915 to join the Canadian Army Medical Corps Nursing Service. The greater part of four years was spent in France and Belgium, at No. 1 Canadian General Hospital, at Étaples, No. 1 Canadian Casualty Clearing Station, No. 3 Canadian General Station, Boulogne, and No. 9 Canadian General at Moore Barracks and Rhyl, Wales. She had the privilege and honour of receiving the Royal Red Cross from His Majesty King George.

Upon return to Canada and after a year's rest, Miss Auger went to Grande Prairie in the Peace River district to help organise the local cottage hospital under the municipalities. In 1922 she resigned that position to take over the duties of Superintendent of Nurses at the Medicine Hat General Hospital, which position she held until her death.

Deeply interested and active in provincial nursing affairs, Miss Auger served continuously as a member of the Council of the Alberta Association of Registered Nurses, and for the greater part of the time she was Chairman of the Nursing Education Section. The nurses of Alberta will miss very much her sane and progressive judgment, especially needed in future, as the Alberta Association of Registered Nurses receives the cooperation and assistance of the Senate of the University of Alberta in the development and advancement of nursing education.

Report of Unemployment Among Nurses in Alberta

[NOTE: At the annual meeting of the Alberta Association of Registered Nurses, Miss Phillipa Chapman gave a report on the unemployment situation among nurses in Alberta. This report is published verbatim.]

The year of 1931, just passed, will go down in our memories as one of the blackest. We hear the words "Depression and Unemployment" every day until we are weary of the sound of them. Probably none is unaffected by their reality. In our own profession, the private duty nurses feel it the most, as their ranks are swelled by nurses who formerly had regular employment in doctors' offices, etc., and by the ever-increasing number of new graduates and by nurses returning from the United States, where they had employment and in many cases fine positions, and now have been squeezed out by the natural demand of the American nurses that they be given the preference. I should like to voice here appreciation for what is being done by some hospitals to cope with the situation. One institution is giving one week's holiday without pay, but with meals provided, to its general duty graduates, and is employing several extra graduates this way. Another institution aids its young nurses, who having completed their training periods, have not graduated. They are permitted to stay on at the hospital and are given a small salary and if possible a "special" case. Though the remuneration is low, this is very helpful, for as every private duty nurse knows, regularity and permanence of income are very desirable, making for freedom from worry and apprehension as to future prospects.

Unemployment among private duty nurses does not seem relieved, and it was hardly anticipated that it would be during the past winter. In view of this fact, that is, that this condition may continue for some time, the Edmonton Association of Graduate Nurses anticipated calls for assistance by nurses seriously embarrassed financially, and the Mutual Benefit and Loan Fund was raised. The appeal for funds met with a very generous response, and a substantial sum was collected. It was contributed to by salaried nurses in the main; that is, institutional, public health and V.O.N., and also by a few of the more fortunate of the private duty nurses, although they were not canvassed for subscriptions. It was felt that private duty nurses would be more likely to be in need of assistance, but only two applications have been received, one from a private duty nurse and one from a hospital employee.

Considering the tightening of money, it is somewhat surprising that we have encountered very little actual distress, but perhaps nurses are reserved about telling the world of their difficulties. We hear sometimes of one here and there who has valiantly risen to the occasion and is trying to make the best of things by working in a store, or café, or doing housework.

After having read Dr. Weir's report, we are brought to a fuller appreciation of the evidently unsatisfactory state of nursing affairs, and this gives us much food for thought. Perhaps a system can be gradually worked out to put nursing services within the reach of more people. A few of Dr. Weir's suggestions are: "Higher standard of education for the graduate nurse. Hourly nursing; group nursing, and employment of more graduate nurses in hospitals, and a system of State Health Insurance," which latter is already a project of the present session of the Legislature of the province of Alberta.

In conclusion, let us hope that the clouds of depression and worry will soon be blown away, and the sun of prosperity shine again. Whatever the future holds, the nursing profession has proved it can meet it with courage, and a singular lack of complaint. For the Private Duty Section, we hope for a bigger and better year.

Department of Nursing Education

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A Suggested Plan of Health Service for a Hospital and School of Nursing Personnel

By MARION LINDEBURGH, Assistant Director, Teaching in Schools of Nursing, McGill University, Montreal, Que.

HEALTH SERVICE FOR STUDENT AND GRADUATE NURSES

There yet remains for discussion a plan of health service to be adapted to the needs of students and graduates in the Department of Nursing. From the hospital point of view the general objectives would be the same for this particular department as for other hospital departments. One significant factor that should emphasize the outstanding need of health for nurses is in the fact that the nurse comes in closer and more continuous contact with the patient than any other member of the hospital personnel. The correlation between physical and mental health and nursing efficiency cannot be overestimated.

Many factors in the maintenance of health in the student body, is more directly the responsibility of the principal of the nursing school, than the superintendent of the hospital, but it is only through more favourable living and working conditions, to be provided by the hospital administration, that the director of nurses can set up and maintain an effective health service for student nurses. This has been, and is today, a very vital issue in the whole problem of Nursing Education. The health of the student nurse cannot be given its fullest consideration until the plan of education in its relation to hospital nursing service is adjusted to a very considerable degree.

A health office should be provided in the nurses' residence and a competent graduate nurse who has had a graduate course in Health Education would be the desired director.

Every student should have a complete health examination upon entering the school. In this connection the services of a doctor will be required. Should a student's condition be such as to indicate her inability to undertake the course she should not be accepted. This aspect of a health service is a well-established function in many nursing schools, and its value is fully recognised.

An immunisation programme has been undertaken in nursing schools for some time, and because of the youth of some of the students entering the schools today, immunisation against scarlet fever is also being provided.

A very important function of a health service for student nurses should be a plan of supervision throughout their period of education. Correction of dental and visual defects should be imperative. Through weight scores and periodic health examination an index of the students' health should be available at any time. The following extract from a nursing journal suggests a situation deserving of serious consideration. "It is a well known fact that certain life assurance companies have discontinued the granting of disability

benefits to nurses. It has been shown that the incident of tuberculosis in student nurses is one-third higher than in other women of the general population."

The hospital and the school of nursing have a very definite responsibility in this matter of student health. From the hospital point of view, it is good business to keep up a high standard of personal health among nursing members, but the nursing school has a greater and a moral obligation to fulfill to the students: firstly, as individual members of society; secondly, in their development for professional service — in which health is a fundamental requirement. The very nature of the nursing activity, with its present-day emphasis on health teaching, is sufficient to indicate the importance of health as a part of the professional equipment of every nurse. She should be able to demonstrate in appearance and in practice, that which she is attempting to teach. To recognise that health is of meaning and significance—not as an isolated end in itself but in relation to other life values, is of tremendous importance today. Professor Bonser, of Columbia University, in an address, "An Educational Perspective," says, "It is my philosophy that the purposes of life, health and education are one. In the long run efficiency, satisfaction and enjoyment all depend upon the healthful functioning of body and mind. Health is a factor which affects our thinking, our feelings, and our acting—our behaviour in waking or sleeping, not less than one hundred per cent. of the time."

In order that healthful attitudes and ideals may become an integral part of the personality of the nurse, it is very essential that the health director possess a personality sufficient to gain the full confidence of the students. They should feel free to confer with her at any time. In the Bellevue nursing school in New York City, where a very successful health programme is in operation, the graduate nurse who has charge of the health of the students also teaches the course in Health Education. This is most commendable in that her interest, understanding and contact with the students in the health office establishes that *rapport* which is so necessary for effective teaching and learning.

For many reasons it is appropriate that the health director also be in charge or have supervision of, the nurses' infirmary. If she is a person truly interested in the welfare of the students, giving spontaneously of her time and effort and making her presence and services of indispensable value, it is to be recognised that she is performing a full time function.

In conclusion it might be said that "a hospital cannot be separated from the problem of health." It carries a responsibility not only to its patients, but to all its employees and to the school of nursing. The hospital, however, can but set up the machinery whereby health may be maintained. Its fullest function can only be secured through the co-operation of all departments and through the recognition of the health service as a valuable facility, of which all should take advantage.

NOTE: Part One of this paper, dealing with the Health Service of a Hospital Personnel, was published in the May issue of the Journal.

Announcement was made in the May number of the *Journal* that an address by Dr. A. T. Bazin, of Montreal, dealing with the Survey Report would be published in this issue. In view of discussion of the Survey Report at the General Meeting of the Canadian Nurses Association, June 21-25, 1932, the Publications Committee has decided that Dr. Bazin's address be not published previous to that meeting.—The Editor.

In Consideration of the Small Hospital School of Nursing After Reading the Survey Report

By C. E. GUILLOD, Superintendent, Maple Creek General Hospital, Maple Creek, Sask.

As a small school of nursing executive the writer can safely say that occasionally at least the town or small city provides a community background and social life suitable to the needs of the small school. The matter of the size of the hospital permitted to retain schools of nursing will rest with the large hospitals, which hitherto have been generous in granting affiliations, as no small hospital can of itself provide the variety of clinical experience necessary. While it is much easier to teach in the classroom of the large hospital where there is a fully equipped teaching unit, the writer has found it easier to correlate theory and practical work in the small hospital. It often happens that a nurse who has trained in a school in connection with a small hospital and had part of her training in affiliation in larger schools is less insular than one who graduates from a hospital of 100 or 200 beds. Also, she may be more adaptable and more ready to nurse all types of cases, especially in the rural districts, than is the graduate of a large hospital. The small hospital does inculcate a love of nursing. There is bound to be keener interest in a patient whose illness is followed by the student from admission to discharge.

It is most necessary that the personnel of the teaching staff be all that could be desired in the matter of personal influence, as well as fitness from an educational standpoint, and it is certain that executives will have to be drawn from the largest schools.

Problems which may have to be considered in the small hospital school of nursing are: that boards are not always sufficiently versed in the qualifications required in those who instruct; that qualified instructors do not care for smaller communities; and that the equipment of the hospital for making physical examinations of the student is not adequate. On the other hand, the student receives a good deal of personal supervision and care that are more difficult to give in the larger hospital.

Before deciding that the small school has no contribution to make toward nursing, it must be considered whether the small hospital can meet the local needs of the community without employing under-graduate staff. There are too many graduates from schools of all sizes who feel free on graduation to regard social life as of more importance than professional duty, when they find themselves away from the restrictions of school life. Unfortunately the small community encourages this freedom.

The number of nurses graduating from a small school and remaining in the nursing field is more or less negligible often, because so many use their training only as a preparation for a larger vocation in life. The small school should not be allowed to exist if in so doing it lowers the standard of all training schools. In the writer's opinion the development of the personality of the student nurse is of more importance than the size of the hospital where she receives her training. Her ideals are so much influenced by the vision of her instructors that the personnel of the teaching staff — both doctors and nurse instructors—is of the utmost importance.

Let us hope that nursing will not become less of a true art in the zeal for perfecting the mechanism of nurse education.

Department of Private Duty Nursing

National Convener of Publication Committee, Private Duty Section,
Miss CLARA BROWN, 23 Kendal Ave., Toronto, Ont.

What of the Future?

By E. PODEEN WILLIAMS, Hamilton, Ont.

In contemplating the details of our own future most of us "See through a glass — darkly." We vaguely picture the final years of life in surroundings probably similar to or even better than those we enjoy today.

Such a pleasant vision may lull us into a false sense of security. Look at the matter from the point of view of other people's experience. Each one of us has, in our circle of acquaintances, at least one elderly nurse who must pass the remaining days of life scraping along on an insufficient income.

These women at one time lived comfortably and felt independent and self-reliant. They enjoyed a good income and were self-supporting. Now independence has become dependence. Why? Because they did not make adequate provision during their working years for the inevitable period when they could not obtain remunerative employment. Life can become burdensome if the "Sunset years" are empty of all good and pleasant things. It is better to forego some luxury early in life than to be left without means of ordinary subsistence later on.

The problem of old age independence is primarily a personal one. We must each find a personal solution. In common with every other achievement a successful old age income provision can result only from a sound pre-arranged plan, carried through in a determined manner. Such a plan must be decided upon and put into operation when we are at the height of our career. Delay is dangerous. If life may last far beyond our income-producing years then our problem is to accumulate enough capital during those working years to provide an income when we are old—for then we still must live though we have no earned income.

Take a pencil and a piece of paper and do your own figuring. Bear in mind the added leisure which will be yours after retirement, allow for basic living expenses and any contemplated luxury, then fix the amount of monthly income you will require. If you happen to be one of those few lucky people holding a position which entitles you to a pension, deduct the pension from your estimated retirement income (but please remember that a professional pension is rarely enough in itself)—don't let the fact that you may get such pensions lead you away from further consideration of your old age income problem.

Then put that pension on a yearly basis—how much money will you need at retiring age to *guarantee* that income for say 10 years, 15 years or 20 years? You can approximate this figure easily. Now, how much will you need to guarantee that income to last as long as you do? This is really a difficult question. You can't afford to take a chance on your capital running out if you live to extreme old age. If you can solve this last problem you must still decide on a savings plan, you must

know how much to put away each year and you are even then faced with the safe investment of our savings until retirement age is reached.

Thus you will see three main elements which must be present in your income plan:

(1) A definite savings scheme.
(2) Safe investment of the money saved.
(3) Some guarantee that the fund saved will be sufficient to provide an income as long as you live.

Being nurses and not financial experts these seem to be insuperable difficulties. It has, however, been my privilege to find a solution to this apparently difficult problem in a way which takes complete care of the three elements quoted above. The beauty of my solution is that the whole matter is all arranged in one simple contract. I am passing this solution on to you. I find that most insurance companies have a Pension Investment Bond or a Deferred Annuity Contract which will provide complete retirement income service in the simplest way. For a fixed annual deposit made between the present time and the time you intend to retire, a guaranteed monthly income will be paid from the time of your retirement. This income is absolutely guaranteed as long as you live. The insurance company assumes the responsibility of paying your income regularly month by month. The annual deposit is fixed and measures the limit of your obligation. You have every incentive to save; the necessary element of compulsion is present. You have no investment difficulties. You are not exposed to the risk of loss which is attendant upon individual investment. Your bond and hence your future is financially guaranteed by the total assets of the insurance company. In addition to these benefits the return from a pension bond is as good as that you could earn on any first-class investment of your own selection.

These bonds are designed to provide an individual solution to every retirement income problem. There are certain variations and certain additional features which when properly combined will adapt the bond to your own particular need. If you have dependents they can be protected if you feel you ought to provide for them.

In your own interests I would ask each one of you to determine the income you will require after you have retired. Consult an insurance man as to just what deposit will be required from you to guarantee the pension you have fixed. Make that yearly deposit your first responsibility. This is not an expense—it is a saving in every sense of the word. It is the least you can do to help that old woman you will become. Budget for your deposit month by month. You will be surprised how easily you can save the necessary money. Buy such a bond and you will really be delighted to find how much happier you will be, how much more content you will be and how much more enjoyment you will get out of spending the remainder of your income knowing that your future financial independence is absolutely guaranteed.

Department of Public Health Nursing

National Convener of Publication Committee, Public Health Section,
MARY F. CAMPBELL, 344 Gottingen Street, Halifax, N.S.

*The Nurse's Place in Industrial Health**

By WILLIAM A. SAWYER, M.D., Medical Director, Eastman Kodak Company, Rochester, N.Y.

When a graduate nurse enters the public health field, and particularly the industrial nursing field, a new opportunity presents itself, for here emphasis is being placed on keeping the so-called well people well, thus preventing much needless disease and disability. Here health is a positive thing, and its maintenance, by avoiding sickness, is the goal. In industry we deal for the most part with so-called well people, endeavouring to educate them to better ways of living by taking care of little ailments or defects before they become serious. Here we see disease in its earliest beginnings, much earlier than a nurse ever saw it in the hospital or in private duty work.

In the examinations of applicants for work, the nurse has her first contact with the worker. If she is doing her task in the best "human relations" fashion, she will want to make this rather trying experience as pleasant and profitable as possible for the employee. Usually the nurse makes the preliminary tests and records some of the history. By her manner she can put the individual at ease, secure from him truthful information and lay the foundation for future happy relations. Later when this employee is seen about correcting the physical defects found, the nurse again exerts her good influence in explaining the importance of having such things taken care of. Teeth, tonsils, eyesight, weight, blood pressure, habits, etc., are all deserving of attention. It is an educational and confidential adviser's job. I have seen nurses take great delight in getting an individual to do things that everyone knew were necessary and wise. Overcoming natural resistance due to fears or ignorance, sometimes due to cost, is always a victory that gives a thrill—if she is interested in people sufficiently and has the patience to labour with them sympathetically and forcefully. This sort of thing is not what the nurse learned to do in the hospital while in training, but it is a thing for which her training and previous experience in the hospital were a splendid background. With it she should have an understanding and appreciation of human tendencies and weaknesses which enable her to handle effectively the many individual problems which confront her.

Attitude Toward the Job

It is the practice in industry to have employees go to the nurse with all manner of small complaints and ailments—very insignificant things she may think at first, but really most important because, as she sees these same people again and again, she will come to realise that here are the po-

(*From "Public Health Nursing" and published by courtesy of the Secretariat of the League of Red Cross Societies.)

tentialities of what later may become very big and serious difficulties. We all know that most people do not visit the doctor until they are really sick and they seldom have a chance to see a nurse unless it is in the hospital. It costs good money to go to the doctor, and naturally it's an expense to be avoided as long as possible. But in industry, if someone comes to the nurse repeatedly for a headache remedy, she will make inquiry, refer him to a private doctor to have that headache, which is a warning signal, investigated. No telling what may be avoided by correcting the cause. It may be an ailment small now, but a thing which may eventually lay down the wage-earner of a family. Again and again the nurse will have many opportunities to advise, to teach and counsel. It is really so much more satisfying than just patching up one who is oftentimes beyond real permanent help.

In the treatment of those injured at work, the nurse, of course, experiences the sort of work she saw in the hospital, but even here a new attitude is apparent. Effort made to bolster up the mental attitude often prevents disability of the mind. Dr. Foster Kennedy, of New York City, has drawn attention to the well-known fact that the amount of trauma is no measure of neurosis which may develop. Oftentimes the less the trauma the greater the neurosis. We must remember that many times workers are more solicitous about their jobs than about their health. Either because of wrong handling at the start, unwise remarks by the doctor or nurse, or because the one injured is inherently susceptible to such end results, these unfortunate cases develop. By prudent sympathy, constantly keeping in mind the return of the injured one to a good functional working capacity in a reasonable time, taking advantage of occupational therapy and rehabilitation procedures, the disability may be shortened and ultimate cure made more certain and prompt. Here massage, baking and other physical therapy give the nurse her great chance to see what first seems a hopeless invalid changed to a completely rehabilitated individual. Repeatedly I have seen cases come around in a most miraculous manner, due entirely, I believe, to the mental attitude and determination of the nurse. Oftentimes the personality and whole emotional slant of such individuals are changed. They are less fearful, more self-reliant, neater about their person and always loyal supporters of the medical work. This surely is glorious achievement. Here the doctor is helpless without the right nurse.

Perhaps the nurse in industry may find herself in a home-visiting position or it may be a combination of inside and outside work. In a visiting position she takes on more of the attributes of a social worker—certainly she is the better fitted to tackle such a job if she has at least an understanding, or better still, some actual training or experience in social case work before she goes into industry. Usually the visiting does not include bedside nursing. It is chiefly a friendly call to determine how sick the worker is and what advice may be given in assisting the worker to get back to health and his job. Here, rare diplomacy coupled with keen insight and analysis of the situation are the requisites. It is no simple door-knocking and "how-do-you-do" job, but one in which some knowledge of psychiatry and psychology both play a part. Many important situations arise, calling for tact, discernment and sound advice. Here is an educational opportunity for the most avid.

Vitalising Routine

I know there are so-called finger wrapping jobs. I have seen them. I would not want to be aligned with such a situation nor would any progressive nurse, I am sure. Usually, however, most of these finger wrapping jobs can be developed into something more. Even when a nurse is but one of a large staff and only does dressings of one kind, she can make of her job, I believe, something more

than a purely mechanical, repetitive task. If she is interested in those people she does things for, believes in herself and the cause for which she labours, and has something more than the average person's understanding of life, she will begin to see the pleasure and value in just a friendly smile or a cheery word. Nurses often make reputations on such things, and a pleasant personality alone puts her above the average. Added to this, a query about the job, the family or their health, with a sage bit of advice, or any one of a dozen things, such as an explanation of why one should care for his health or why one should drink more water or get more sleep—and you have indeed raised a humdrum thing to a calling. The nurse who finds zest in her work is one who is constantly trying to solve the riddles of life, who reads voraciously of the things that enlarge her vision and sphere of understanding, and who in time finds satisfaction and value in transmitting some of this to those less fortunate. Is this more than private duty care of the sick; is it more than most public health jobs? It is something definite and concrete—a programme which conserves and builds.

Radio Health Talks

The following is one of the many appreciative messages received by the Department of Health and Public Welfare of Manitoba from a public health nurse:

"During a recent visit to Birtle and district, I accompanied Miss —— to every home in the municipality, and was much interested to find the number of people who were 'listening in' to the radio health talks as given by the Department of Health and Public Welfare. They were, without exception, unanimous in their praise of the value of these talks.

"In one instance we had much difficulty in obtaining an answer to a rap at the door. When finally the lady of the house did appear, she said: 'The health talk is going on and I feel I need to get all the advice I can on my health, so I just sit down and drink it in.' We crossed the road to the next house to give the first lady an opportunity to finish 'drinking' the health talk. There we found it the same. The family were seated at the dinner table, listening to the health talk. Miss ——— and I decided we might just as well take the noon hour off on Tuesdays and Fridays as the people were all too engrossed in the health talks to admit callers.

"From my experience in the rural districts, I would say that the radio has been responsible for at least fifty per cent. of the publicity given the Department of Health and Public Welfare, and hope that this very valuable means of education may be continued, particularly for the benefit of those in the more remote parts of the province."

Nova Scotia—Its Possibilities for Vacationists

The natural Ocean Playground known as Nova Scotia is a magnet to beauty lovers, who journey thither, year by year, in constantly increasing numbers. Many of these drive their cars in overland. Others have their cars conveyed to the province by steamer from Saint John, New Brunswick; from Boston; from New York, and from Philadelphia.

The motorist who drives his car into Nova Scotia overland crosses the Missaquash River, which separates Nova Scotia from her sister province of New Brunswick, and traverses the famous Tantramar marshes to Amherst. In the neighbourhood are the grass-crested mounds of two famous forts—Lawrence and Beausejour—relics of the titanic struggle between France and Great Britain for the mastery of North America. The embankments and entrenchments are still to be seen and attract an increasing number of history lovers year by year. Each motor route has distinctive charms all its own. A short route to Cape Breton Island is by way of Amherst and New Glasgow, along the attractive gulf shore of Nova Scotia, where there is excellent boating and warm salt water bathing, together with bracing sea air, sport fishing and bird shooting. This district was early peopled by settlers from the old colony of New York, who, in 1784, sought refuge here after the War of Independence.

Salt mines are found in the peninsula of Malagash: the deposit of pure white salt here is estimated at 25,000,000 available tons.

Parrsboro is a popular resort on the Basin of Minas, waters celebrated in legend and song, with good fishing and shooting in the neighbourhood. From here a steamer makes daily trips across the Minas Basin to Wolfville in the heart of the Evangeline country.

Truro, settled by New Englanders, a railway divisional point and the seat of several educational institutions, is situated in one of the outstanding farming regions of Canada. The Agricultural College and Farm are well worth a visit, and a wide range of entertainment is offered by numerous sport and athletic clubs. Victoria Park is a magnificent natural playground of 1,000 acres, with a picturesque waterfall.

From Truro, across the beautiful valleys of the Stewiacke and Shubenacadie rivers the road sweeps to the Grand Lake district, then past the lovely Waverley lakes into a wooded country, emerging on a hill overlooking the magnificent Bedford Basin, which forms a portion of the harbour of Halifax, one of the finest in the world.

The old-world city of Halifax, with its impressive Citadel and lovely North West Arm, has an individuality all its own. The historic Province House, often spoken of as the finest specimen of the Georgian type of architecture on the continent, contains many valuable portraits and relics of interest. The Public Gardens, founded in 1753, are famed for their beauty. In St. Paul's Church, the oldest Protestant Church in Canada, are interred many men distinguished in the history of Canada. Numerous interesting historic sites throughout the city have been marked with tablets by the Nova Scotia Historical Society. There are four golf courses in the vicinity—three of them 18-hole courses—offering a wide variety of attractions, with magnificent vistas, rolling surfaces and an abundance of natural hazards.

All lovers of the beautiful revel in the bays along the south coast line. There is Saint Margaret's, so named by Champlain; Chester, Mahone, Liverpool, Jordan and Barrington.

These bays sweep deeply inland, with curving sand beaches, while mysterious wooded islands lie off-shore. Farther on is Lunenburg, one of the greatest fishing ports of the continent.

At Fort Point, on La Have River, known as the "Rhine of Nova Scotia," may be seen the remains of a French fort, erected in 1632. The view from the hills is one of the most memorable in Nova Scotia. Within easy reach of Liverpool, which occupies the site of an ancient Indian village, are four splendid sand beaches. During the American Revolution and also during the war of 1812, privateers were fitted out at this port and brought back stores of wealth. From Liverpool through glistening white sand dunes to Port Mouton one comes to Shelburne, situated on an elevated plateau overlooking one of the finest land-locked harbours. Founded by citizens of New York City after the War of Independence, Shelburne is redolent of historic lore, and a noted fishing and ship-building centre.

Yarmouth, one of the principal entry points of Nova Scotia, is only a few hours from Boston. It is a charming town, with old English hawthorn hedges and a broad and pleasing harbour. In Acadian villages that border for thirty miles the shore of Saint Mary's Bay one may discover some of the old customs, a few of the costumes, and much of the old Acadian speech of Evangeline days.

Near the mouth of Annapolis Basin is the famous summer resort known as Digby, with a daily ferry steamer to Saint John, New Brunswick, which carries cars. Nearby is Bear River, a most picturesque place and known as the Switzerland of Nova Scotia, and Digby Neck, with the rolling hills and nestling villages with their feet in the blue waters of Saint Mary's Bay.

Along the Annapolis Basin—a long and strangely beautiful body of water, is the historic town of Annapolis Royal, founded in 1604, the oldest town north of the Gulf of Mexico. Here is Fort Anne, steeped in romance, which has been set aside by the Dominion Government as a National Park. A fine view of the ramparts is found on the golf course, with the wooded slopes of the North Mountain as a background. Here, too, is the famous Annapolis Valley, one of the great apple-growing countries of the world. Two million barrels of apples were grown there last year, and as yet not more than twenty per cent. of the land suitable to apples has been set out to trees. In the springtime there are one hundred miles of white and pink blossoms—a world of bewildering beauty that holds the observer spellbound.

Further on is Grand Pre, known to every schoolboy and school girl. Thousands of visitors from all over the world visit Grand Pre every year in order to see the treasure house of Acadian memorials which has been established there.

Windsor is the chief centre of Hants County and combines the advantages of a modern shipping port with the charm of the old world town. The phenomenal tides of the Bay of Fundy, rising to forty feet at flood, may be seen here to advantage.

From New Glasgow one passes inland through an interesting farming country to Antigonish—a university town—beautifully situated amidst immense shade trees and surrounded by high hills. Farther on lies the Strait of Canso, on which a modern motor ferry conveys tourists to Cape Breton Island. On the shores of the wonderful Bras d'Or Lakes is Sydney, one of the great steel-making centres of Canada, also Louisburg, with its dramatic and tragic history, which exerts a subtle yet powerful influence upon the mind of the visitor.

Baddeck, one of the world's gems, is found in the historic Island of Boularderie. The Bras d'Or Lakes, on which the town is situated, are inland sea lakes, practically tideless and of great beauty.

Canadian Nurses Association

By the time this issue of the *Journal* reaches the nurses, the federated associations will have named official representatives to the Sixteenth General Meeting of the Canadian Nurses Association.

The total number of delegates from these associations is sixty-eight. According to the by-laws of the C.N.A. each organisation is entitled to one vote for every fifty members until the maximum of ten votes is reached. Four provincial associations have reached the maximum number of votes, three others have a membership giving them seven votes, one has six and one has one vote.

All members, including delegates, are asked to arrive in Saint John so that they may be present for the opening business session, which is scheduled to commence at 9.30 o'clock on Tuesday morning, June 21st. The business of the C.N.A. will be continued into the afternoon session, while in the evening at an open meeting the C.N.A. will receive its official welcome to New Brunswick, and the Hon. Vincent Massey will give an address on "The Public and the Survey Report." This brief outline is sufficient proof for stressing that all nurses arrange to reach Saint John previous to the first session.

The Executive Committee, the officers, the chairmen of sections, and four councillors from each provincial association are expected to attend meetings of the Executive Committee, C.N.A., as well as those of the Sections. The latter open at 1.30 o'clock on Monday afternoon, June 20th, with the general Executive at 2.30 p.m.

As previously announced, the Report of the Survey of Nursing Education will be the subject for discussion by nurses at three sessions, i.e., Wednesday morning and afternoon and Friday afternoon. The point of view of the scientist, the educationist and the medical profession in regard to the Report will be interpreted following the banquet on Wednesday, and on Friday evening.

The Sections will meet concurrently on Thursday afternoon and Friday morning. The final general business session takes place on Saturday morning, followed by the Executive Committee meeting in the afternoon.

Interspersed throughout the week there will be opportunities for social relaxation arranged by the New Brunswick Association of Registered Nurses, when visiting nurses will enjoy the hospitality for which the people of the Maritimes are renowned.

The Admiral Beatty Hotel will be headquarters for the Canadian Nurses Association for convention week. The management assures excellent accommodation for all sessions and for the comfort of the nurses as guests. Reservations should be made at once if not already procured.

Canadian Nurses Association

NOMINATION TICKET, 1932

For President: Miss Florence H. M. Emory, Assistant Director, Department of Nursing, University of Toronto, Toronto.

For First Vice-President: Miss Ruby M. Simpson, Director, Public Health Service for Saskatchewan, Regina, Sask.

Miss Mildred Reid, Practical Instructor of Bacteriology, Manitoba Medical School, Winnipeg, Man.

For Second Vice-President: Miss Gertrude M. Bennett, Superintendent, School of Nursing, Ottawa Civic Hospital, Ottawa, Ont.

Miss Margaret Kerr, Assistant Director of Nursing, University of British Columbia, Vancouver, B.C.

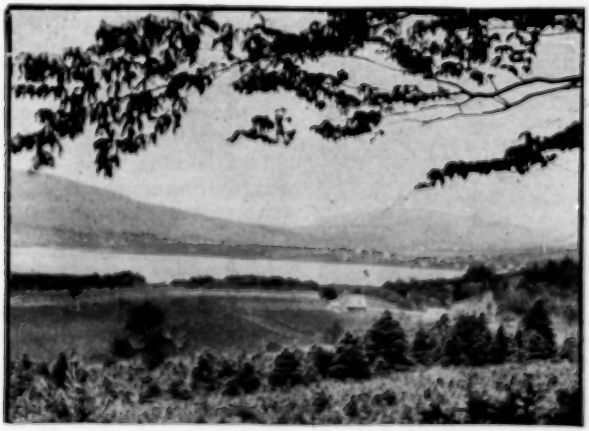
Miss A. J. MacMaster, Superintendent, Moncton General Hospital, Moncton, N.B.

For Honorary Secretary: Miss Nora Moore, Department of Public Health Nursing, Toronto, Ont.

For Honorary Treasurer: Miss Margaret Murdoch, Superintendent, School of Nursing, Saint John General Hospital, Saint John, N.B.

Miss Kathleen Sanderson, Executive Secretary, Greater Vancouver Health League, Vancouver, B.C.

For Programme, in detail, of the General Meeting, see the May number of the *Journal*.



—Courtesy, Canadian National Railways.

Bras d'Or Lakes, Cape Breton.

Report of Annual Meeting—British Columbia

The annual meeting of the British Columbia Graduate Nurses Association was held on March 29th, at St. Paul's Hospital, Vancouver. Interesting meetings were held throughout the day.

During the morning, round table conferences were held by the various sections: Nursing Education, Public Health and Private Duty.

A discussion of "Curriculum Problems," led by Miss Grace Fairley, took place at the Nursing Education Section, following which resolutions dealing with important nursing education problems were drafted to be presented at the general meeting.

Miss Laura Holland, Deputy Provincial Superintendent of Neglected Children, was the speaker at the Public Health Section; her subject being "Co-operation of the Department of Neglected Children." Following the address a general discussion took place.

At the round table discussion of the Private Duty Section the subject was "The Unemployment Situation," led by Miss Mirfield. Time was spent in preparing the report to be presented at the C.N.A. Convention.

At 11.30 a.m. a meeting of the council was held.

At 2 p.m. the general meeting was called to order, Miss Mary Campbell, the president, in the chair. The invocation was led by Rev. Father A. F. Griffith, following which Miss Campbell presented her report for the year. She stressed the need for study groups and sustained interest in the Survey Report if results were to be brought about.

Miss Dutton, secretary, gave her report and also read a synopsis of council meetings held throughout the year.

Miss H. Randal, Provincial Registrar and Inspector of Training Schools, was unable, through illness, to be present, and in her absence her reports were read by Miss Mabel Gray.

Reports from the Nursing Education Section were presented by Miss Gray, convener, and three resolutions were read for which the approval of the meeting was asked.

On the completion of the business, the meeting adjourned to the reception room of the Nurses Residence, where tea was served by the combined Alumnae Associations of St. Paul's Hospital and the Vancouver General Hospital.

Business at the evening session included the reading of the report of the Public Health Section, by Miss Kerr, convener. A proposal from this section for the Association to place two copies of Dr. Weir's Survey Report on the open shelf of the Provincial Library in Victoria was adopted.

The Association was privileged in having two interesting speakers: Miss Jean Browne, Director of the Junior Red Cross, spoke briefly on the enrolment of nurses for emergency service and said that up to the present a total of 576 registered nurses had enrolled.

Dr. George Weir, Director of the Survey of Nursing Education in Canada, gave an extremely interesting address, taking as his subject "The Nursing Survey." "Private duty nursing must be socialised with the control remaining in the hands of the nurses," Dr. Weir affirmed. "Public health nurses today are an example of this type of control, and it is only a question of time until such a system is in operation throughout this country. At present there are 12,000 unemployed nurses in Canada and something must be done to remedy this situation. It is time that individuals should be forgotten in the interests of the masses, and one may

become community-minded without becoming communistic.'' The education of the student nurse was an important factor. The speaker expressed the opinion that in twenty-five years' time a university education would be considered quite as necessary as is a high school education today, and that the requirements for entrance would be character and capacity rather than wealth and social position. Dr. Weir defined education as making changes in the individual and as being an aid to the acquiring of a lofty and sane idealism.

Book Reviews

Health on The Farm and in The Village: A Review and Evaluation of the Cattaraugus County Health Demonstration with Special Reference to Its Lessons for Other Rural Areas, by C-E. A. Winslow, Dr. P.H.; pp. 267; The Macmillan Company, New York, 1931. Price, $1.10.

The sub-title is a concise statement covering the scope and purpose of the book.

In the Foreword the author explains the ''what,'' ''why,'' and ''how'' of his commission. The Technical Board of the Milbank Memorial Fund desired ''an impartial and comprehensive survey of the seven years' experiment of the Cattaraugus County Demonstration with a view to summing up the lessons to be derived from this experience with regard to the general problem of adequate health service for the rural districts.'' Dr. Winslow's reason for undertaking the task ensures a high standard of fact-finding to be followed by a keen analysis of the data for their full meaning. The reason is ''he conceives the problem of rural hygiene to be the most vital one in the entire field of public health.''

Chapter I, Lessons of the Rural Health Demonstration, begins with a description of the area, ''Cattaraugus County, New York State, is a highly typical rural county of the Northwestern United States. It has a fairly stable and homogeneous population of 72,000 persons, mainly of native stock, engaged chiefly in small industry and dairying. It is relatively prosperous . . . having an average per capita annual income of somewhat under $900.00 but with a substantial proportion of its people living at a very low economic level.'' There are two cities in the county: Olean, with a population of 22,000, and Salamanca with 11,000 people.

The first evidence of a felt need in health matters as expressed in action on the part of the citizenry is recorded. Its growth and development are traced to the setting up of the Demonstration plan in 1923.

The type of organisation in Cattaraugus County differed widely from the so-called ''standard'' county health units. It consisted of bureaus to deal with communicable diseases, tuberculosis, statistics, nursing, maternity, infancy and child hygiene. Sanitary engineering was the last activity to receive attention. The author considers this to have been an unwise delay.

A county school hygiene service, a campaign of popular education and a social service programme were also developed. An unofficial agency gave impetus to both of the latter.

In 1927 the total appropriation for public health work from all sources reached its peak at $176,000. In 1929 it fell to $160,000. This represents $2.20 per capita, of which $1.00 came from the county and its local units, 50 cents from the state and 70 cents from the Milbank Memorial Fund. Dr. Winslow estimates that $175,000 or $2.40 per capita would be necessary to cover certain gaps in the programme. In 1930 the County Board of Supervisors increased its appropriation by $10,000, which entailed an equal increase in state aid.

Under the caption Outstanding Specific Achievements and Lessons of the Demonstration are discussed: The County Health Unit—''such development is economically justified by direct returns in the saving of human life;'' School Health Service—''There may be better systems but the one in operation has worked well;'' The Nursing Programme—''one of the most notable achievements of the demonstration has been the creation of a public health nursing service which, taken all in all, is probably unique in a rural area;'' Tuberculosis Control—''It has proved case-finding machinery, clinic service, nursing service, and institutional facilities which . . . are on a par with those of the best cities and are, so far as the writer is aware, superior to those yet provided in any other rural area;'' Nutrition Service—''The studies carried on in the county have contributed materially to our knowledge of dietary problems in rural areas and to the technique of dealing with such problems;'' Care of Crippled Children; Statistical Studies and Social Service were important phases of the programme. The latter revealed ''The extent of uncared-for social needs of a rural population.''

More lengthy discussion of the nursing service might be expected by readers of "The Canadian Nurse." However, the strength of this service, in the reviewer's opinion, is its complete integration with the County Health Department programme, and therein lies the difficulty in treating it as an entity, and keeping within the bounds of the allotted space.

The reader is reminded that a scientific approach to such a study is the only fair or constructive one. "It would be too much," we are told, "to expect that a project of the scope and character of the Cattaraugus County Health Demonstration would do all its teaching through the presentation of positive results. The experience in the development of the health work in the county has resulted in certain conclusions, which for this particular area are drawn from negative results, but are leading to the avoidance of similar missteps in the development of programmes elsewhere."

"Health on The Farm and in The Village" offers much food for thought and, to no small extent, guidance to the rural public health administrator and executive. The style is interesting. The type is clear. There are a number of excellent illustrations and statistical tables. The index is detailed and complete, making subject reference easy. E. L. M.

History of Nursing in the Province of Quebec: by Maude E. Abbott, B.A., M.D.; 97 pages; 42 illustrations. Price, $3.00. McGill University, Canada, 1931.

This book, written by Dr. Maude E. Abbott, who is a recognised authority on Medical and Nursing History, gives an excellent and most interesting account of the development of medicine in the old Province of Quebec, from the time of Jacques Cartier's voyages until the present day. There are many topics presented. Pages 9-31 give a complete picture of Indian Medicine in Eastern Canada, Life among the First French Settlers, 1535-1608, Pioneer Physicians, The Rise of Early French Hospitals and Medical Legislation under the French Regime.

The reader is introduced to the manners, customs and social aspects of this period.

The latter part of the book (pages 32-89) deals with many interesting details concerning the development of Medical Teaching, Great Epidemics, Introduction of Anesthesia, History of the Care of the Insane, Quebec Hospitals Today, and Modern Progress in Movements in the Province of Quebec.

There is a very excellent account of The Origin of The Montreal General Hospital and the establishment of the Medical Faculties of McGill University, The University of Montreal and of Laval University, Quebec City. The reviewer recommends the book to all those interested in history, and particularly to doctors and nurses.

It is of undoubted value in the teaching of Nursing History. A copy of "The History of Medicine in the Province of Quebec" should be placed in the library of all Nursing Schools. M.B.

BOOKS RECEIVED

The Principles and Practice of Surgical Nursing, by C. D. Lockwood, A.B., M.D., F.A.C.S., in collaboration with Mildred E. Newton, B.S., R.N. Price, $3.30.

Fundamentals in Massage, by Kathryn L. Jensen, R.N. Price, $2.40.

A Textbook on Bacteriology, by K. L. Burdon, Sc.M., Ph.D. Price, $3.30.

These books are published by The Macmillan Company of Canada, St. Martin's House, Toronto, Ont.

BIENNIAL CONVENTION—AMERICAN NURSES

The biennial convention of the American Nurses Association, the National League of Nursing Education and the National Association for Public Health Nursing, held in San Antonio, Texas, April 11 to 15, had an attendance of three thousand delegates.

Miss Elnora E. Thomson, Professor of Applied Sociology, University of Oregon, Portland, was selected president of the A.N.A.; Miss Effie J. Taylor, Professor of Psychiatric Nursing, Yale University, New Haven, Conn., as President of the N.L.N.E.; and Miss Sophie C. Nelson, Director, Visiting Nurse Service, John Hanock Life Insurance Company, Boston, as President of the N.O.P.H.N.

The Saunders medal awarded annually to the nurse who has given the most distinguished service to her profession was awarded to Miss Annie W. Goodrich, Dean, Yale University School of Nursing.

The house of delegates decided in favour of the N.L.N.E. as the educational department of the A.N.A., with no change in the structure or autonomy of the league.

The 1934 meeting will be held in Washington.

News Notes

ALBERTA

CALGARY: The April meeting of the Private Duty Section of the Alberta Association of Registered Nurses, the first after the convention in Edmonton, held in Calgary on April 11th, was a pleasant and successful meeting, with twenty-five members present. It was quite a representative gathering, comprising nurses from local training schools and several graduates from other schools. The report of the Private Duty Committee meeting at the recent convention was read and various phases of the nursing situation were discussed with lively interest and all hoped for better things in the future both for patient and nurse. A copy of Dr. Weir's Report was examined with much interest, and it would seem that if the private duty nurses were informed as to the wonderful work which "those higher up" have done and plan to do for the status of all nurses, it would not be difficult to make the private duty sections a valuable part of nursing organisations.

It was decided to hold regular meetings every month, except in July and August, the business to be followed by tea and a social hour. Plans for raising funds were discussed, also the practicability of using the money to inform the public as to the nursing service which is at their disposal. The meeting broke up at 10.30 p.m., with promises on all sides of faithful attendance at meetings and expressions of hope that the Section may be able to do some real work in the future.

EDMONTON: Friends of Miss A. L. Young (Royal Alexandra Hospital, 1922) are pleased to know she is progressing favourably after her operation at the University Hospital.

BRITISH COLUMBIA

GENERAL HOSPITAL, VANCOUVER: The April meeting of the Alumnae was held in the Auditorium, the president, Mrs. Ernest Gillies, in the chair. The speaker of the evening was Mrs. Stuart Jamieson, who is very well known for her interest in international affairs. Mrs. Jamieson spoke of the relations of China and Japan, and gave a good deal to think about in these times of daily newspaper reports of the constant warring. This lecture is to be followed by two others at later meetings on current events. Plans were made to entertain the graduating class next month. All are taking quite an interest and looking forward to a "Country Fair" in the Auditorium in a very short time where the old and new graduates may join hands in merry-making. Miss Doris Bullock (1922) has been appointed to the Rotary Clinic staff. Miss Rae McNabb and Miss Olive Walker have joined the staff of the City Welfare and Relief Department of the City. In a recent letter from Mrs. Charles Thomson, Shanghai, formerly Freda Lang (1922), news was received of many of the Alumnae who are at present in the Orient. Mrs. Janet Scott and Miss Witcher who were on the staff here have arrived from Honolulu, returning there again in May. Miss Macinrot who was on the Isolation Hospital staff here is also in Shanghai. Mrs. Thomson has seen a good deal of these nursing friends and expresses relief at the more settled conditions in China. The constant booming of guns and aircraft over the International settlement was very trying to everyone, even if they felt no actual danger. Mrs. MacDonnell, formerly Maude Wooster, is also living in Shanghai and it is understood that the former Marion Fisher (1922), now married, is returning from China on furlough this fall. Both these nurses have been in China for many years. Miss Muriel McIntosh (1925) is now busy learning the Chinese language before taking up her work in the Mission Hospital at Chengtu, Szechuan, West China.

MANITOBA

GENERAL HOSPITAL, BRANDON: The Graduate Nurses' Association entertained the graduating class of the General Hospital in the dining room of that institution. Specially invited guests were: Miss C. Birtles, Miss Jean Houston and Mrs. G.R. Lyons. Mrs. E. A. Whitmore, the guest speaker gave an interesting address on "Keys of the Kingdom". The colour scheme of mauve and pink was carried out in the decorations of the room and table. Toasts were proposed to the medical profession by Miss G. Hall, and responded to by Dr. Anderson, to the Graduating Class by Mrs. Pierce and responded to by Miss Jean Myers. A pleasing feature of the evening was a musical festival of original songs rendered by various groups. The annual meeting of the association was held on this occasion when reports were made by the members of the executive, and a vote of thanks rendered to the retiring officers.

ST. BONIFACE HOSPITAL: On April 13th the Alumnae entertained the 1932 graduating class at a dinner in the spacious banquet hall of the Nurses Residence. In charge of the arrangements were: Misses Theresa O'Rorke and Clara Miller, assisted by Misses Kae McCallum, Nan Gordon, Eileen Pettit and Evangeline Edwards. The president, Miss Etta Shirley and Miss E. Parkhill received the guests. A unique feature of the evening was the presence of the first two graduates from St. Boniface Hospital, Mrs. Henriette Crossby and Miss Marion S. Suttle, they having graduated in 1899. The tables were attractively decorated with the class colours, blue and gold, and Talisman roses, daffodils and hydrangeas. During the evening a programme of music was contributed.

The Alumnae members were pleased to have the quarterly meeting of the Manitoba Association of Registered Nurses held in the assembly hall of the Nurses Residence on April 29th.

WINNIPEG: The Graduation Exercises for the School of Nursing, St. Boniface Hospital, were held on May 16th in Provencher Collegiate Institute Auditorium; those for the Winnipeg General Hospital School of Nursing took place in Grace Church on Friday, May 27th, and on the evening of May 31st, the same were held for the Children's Hospital graduating class. All were followed by receptions in the Nurses Residences.

NOVA SCOTIA

NEW GLASGOW: An association of graduate and registered nurses has been formed at New Glasgow, under the name of "The Pictou County Graduate Nurses' Association". Meetings are held on the third Friday of each month at the Nurses Home, Aberdeen Hospital. Four meetings have been held with an average good attendance. Matters of importance regarding the present situation of nurses have been discussed with keen interest, and the association shows promise of a progressive and beneficial future. Following is a list of officers: Hon. President, Miss Margaret C. Macdonald; President, Miss Daisy Gray; Vice-President, Miss May McMillan; Secretary, Miss Ethel Elliott; Treasurer, Miss Hilda Meikle; Executive Committee, Mrs. Edison Fraser, Mrs. J. W. McLeod, Misses Marion P. Boa, Nina Grant, Helene Townsend; Representatives: Private Duty Section, Miss Mabel McPhee, Miss Jessie Oliver; Public Health Section, Misses McKenzie and Robertson; Local Council of Women, Mrs. W. H. Robbins Miss Daisy Gray, Mrs. Jos. Morris, and Mrs. R. A. Douglas; "The Canadian Nurse" Misses Jessie Robertson, Calder and Douglas; Sick Visiting Committee, Mrs. A. Enman, Miss E. C. Cowan; Refreshment Committee, Miss B. B. Kennedy.

ONTARIO

Paid-up subscriptions to "The Canadian Nurse" for Ontario in May, 1932, were 932, twenty more than in April, 1932.

APPOINTMENTS

HOSPITAL FOR SICK CHILDREN, TORONTO: Miss Eleanor Newberry (1925), who has had charge of the O.P.D. for five years, has resigned, and Miss Masten (1930) has been appointed in her place. Miss Isobel Hamilton (1930) is doing floor duty at the Women's Hospital, Montreal. Miss Muriel Bazin (1930) has taken charge of a ward in the Children's Memorial Hospital, Montreal.

BRANTFORD GENERAL HOSPITAL, BRANTFORD: Miss Jean Davidson (Brantford General Hospital, 1922) has accepted a position in the X-ray Department of Freeport Sanatorium, Kitchener.

DISTRICT 2

BRANTFORD: The regular monthly meeting of the Florence Nightingale Club was held on Monday evening, May 2nd. Plans were made for the June meeting, to take the form of a picnic at the Bell Homestead.

BRANTFORD GENERAL HOSPITAL: Miss Minnie Brown (1928) is a patient at Grace Hospital, Toronto. Graduation Exercises of the Brantford General Hospital School for Nurses will be held on June 3rd at the Brantford Collegiate Auditorium. National Hospital Day, May 12th, was observed at the Brantford General Hospital. Third year student nurses completed their course in Psychiatry by a visit to the Ontario Hospital, Hamilton, where Dr. J. J. Williams and his staff had prepared very interesting clinical studies. Miss Maude Campion, Miss M. Griffith, Miss E. Ruddy, Mrs. J. N. Mitchell, Miss J. M. Wilson and Miss E. M. McKee, attended the Mental Health Conference held at the Ontario Hospital, Hamilton, on May 7th. Dr. J. M. Robb and Dr. B. T. McGhie were speakers at the Conference.

WOODSTOCK: Miss M. Davison and Miss G. Jefferson represented the Graduate Nurses' Alumnae at the Provincial Convention of the R.N.A.O. held at Chateau Laurier, Ottawa. The Graduate Nurses' Alumnae, of which Mrs. A. H. Melsom is president, held a successful bridge April 8th. The Nurses Residence was made attractive with tulips and daffodils. Receiving the afternoon guests were Miss H. Potts, Miss M. Davison and Mrs. P. Johnston. Conveners of the event were: Miss E. Hastings for refreshments, Miss R. Wright and Miss A. Cook for bridge. A total of forty tables were in play during the afternoon and evening. Miss H. Potts and Miss G. Jefferson welcomed the evening players. As a result of the event a very gratifying sum was added to the funds.

DISTRICT 4

HAMILTON: A well-attended informal dinner and meeting was held at The Towers on April 22nd by the Public Health Section of District No. 4 of the R.N.A.O. for the purpose of discussing Dr. Weir's Report, with Miss Florence Emory, of Toronto, as guest speaker, and Miss Cora Taylor, councillor of the district in the chair. Miss Emory's subject was "Some Aspects of the Survey of Nursing Education in Canada as Made by Dr. Weir". She first gave an outline of the general background of the Survey and its objects, and then dealt with the three sections. The whole question of nursing education is bound up with the finances of the hospital, and under present conditions there is an annual loss to the average hospital for each student receiving satisfactory training in nursing. Dr. Weir draws an analogy between the teaching and nursing groups and suggests that the solution would seem to rest with government participation. Regarding the Private Duty Section, the speaker stated that in 1930 there was a surplus in Canada of 40%. In twenty-five cities in Canada a third

of the population has the services of approximately two-thirds of the registered nurses, but three out of eight patients of moderate means who need these services are not able to pay these nurses. Socialized nursing service would bridge the gap between the needy patient and the unemployed nurse. There should be registration of all who nurse the sick for hire. It was pointed out there is need for Community Health Service and for participation of the public health nurse. In 1930 the supply was equal to the demand. Miss Emory stated that this Survey has been valuable in gathering together facts regarding nursing and has brought together groups who can improve the situation. The hope was expressed that in a few years nurses might look forward to a second survey showing marked progress along the line embodied in the recommendations of this report. Miss Rayside expressed her appreciation to the Public Health Section for bringing Miss Emory to Hamilton, and made it known that copies of the Survey Report were available at the Hospital, and impressed upon all present the necessity of reading the Report.

DISTRICT 5

COLLINGWOOD: A meeting of the Alumnae, Collingwood General and Marine Hospital, was held in the hospital on April 25th. The Honorary President, Mrs. Price and the President, Miss R. Hanley, and nine members were present. The secretary's and treasurer's reports were read and approved. Several discussions followed regarding a medal for graduation, linen for the nurse's room and the purchasing of the Alumnae pin. It was decided to hold a Progressive Euchre at the Nurses Residence on May 13th. Miss S. Johnston, the assistant superintendent, was asked to prepare a paper for the next meeting, choosing her own subject.

GENERAL HOSPITAL, OSHAWA: The annual At Home of the Alumnae Association was held at the Genosha Hotel, on April 7th. Over one hundred couples were present making the evening very successful. Miss Amber Souley and Miss Helen Hutchison were delegates to the Registered Nurses of Ontario Convention held at Ottawa.

TORONTO: A general meeting of the Community Health Association of Greater Toronto was held in Osler Hall, Academy of Medicine, on April 22nd, when one hundred and seventy nurses interested in community problems attended. Reports were read from the Study Committees on Maternal Welfare and the Pre-school Child. Mrs. Harriet Mitchell, Director of Parent Education, Mental Hygiene Institute, Montreal, was the speaker of the evening. Her subject was Mental and Physical Aspects of the Pre-school Child. She outlined briefly the education of the child from the early days of civilisation and spoke at greater length upon the value of modern ideas of parent education and child guidance.

HOSPITAL FOR SICK CHILDREN, TORONTO: Miss Una Ross (1929), is holidaying in Pratt, Kansas. Miss Grindley, Hospital for Sick Children, was a delegate to the R.N.A.O. Convention at Ottawa.

WESTERN HOSPITAL, TORONTO: The regular meeting of the Alumnae was held on April 12, 1932. An interesting item of the programme was the welcoming of the graduating class as members of the Association. An excellent report of the R.N.A.O. Convention in Ottawa was given by Miss Beamish, the president. The guest speaker of the evening was Miss Mary Millman, President of the R.N.A.O., who outlined some of the aims of that organisation and pointed out the benefits obtained by membership in the Registered Nurses Association. Tea was served and a social half hour closed the meeting.

DISTRICT 6

Chapter 3 of District 6, R.N.A.O. held their meeting at Nicholl's Hospital, Peterborough, March 29th, at 7.30 p.m. with Miss Dixon presiding. There was a splendid attendance at this meeting. Several members of the Chapter expressed their opinion that the members should have some worthy object to work for, locally. There was keen discussion over this, finally it was approved that for the present the Chapter work towards a Nursing Benefit Fund, for the members; also, the members decided that a picture be sponsored and that Miss Simmons, with her committee, arrange for the same. Miss Matchett kindly offered her home for three tables of bridge, followed by a Waffle Supper.

DISTRICT 8

CIVIC HOSPITAL, OTTAWA: The Alumnae Association held a tea in the Nurses Residence on May 1, 1932. The guests were received by Miss Gertrude Bennett, Miss E. Maxwell and Miss Evelyn Pepper. Over one hundred members were present. Mrs. Eldon Veitch and Mrs. V. Craig presided at the tea table, and the ices were served by Mrs. Wilfred Parmalee. The following assisted: Misses Grace Froats, Gertrude Maloney, Margaret MacCallum, Winnifred Gemmell, Dorothy Moxley, Beth Graydon, Gertrude Ferguson, Mary Luton, Greta Wilson, Emily Fallas, Margaret Normand and Katie Clark.

QUEBEC

ROYAL VICTORIA HOSPITAL, MONTREAL: Miss E. C. Flanagan (1923), and Miss Riches (1932), are leaving shortly to take post graduate courses in London and Edinburgh. Miss Betty Bartlet (1930) is doing public health work in Windsor, Ont. Miss Dorothy Gordon (1931) is taking a post graduate course at Ste. Agathe Sanatorium. Miss Katherine MacLennan (1930) has accepted the position of Instructor at the Alexandra Hospital, Montreal. Miss Helene Wilson (1931) is doing floor duty at the Shriners' Hospital, Montreal.

SASKATCHEWAN

MOOSE JAW: The Annual Graduation Exercises of the Moose Jaw General Hospital were held in Zion Church on May 3rd. Sixteen nurses received their medals and diplomas.

C.A.C.N.S.

TORONTO: Toronto Unit, Overseas Nursing Sisters Association of Canada, held a very jolly bridge party in the Sisters Quarters at Christie St. Hospital on Friday, May 6th. These reunions of the Club are always most enjoyable as well as remunerative, and the Treasurer reported proceeds of $76.00 from 36 tables at 50 cents a player. Expenses were negligible as the refreshments were provided by members as usual. Mrs. Jack Bell, the president, and members of the executive missed very much the assistance of the genial hostess Matron Hartley, A.R.R.C., who is at present ill in hospital. Miss McCallum represented Miss Hartley and was assisted by Miss Drysdale.

WINDSOR: Miss Agnes Gordon, Miss Myrtle Fielder and Mrs. Watson were hostesses to the Overseas Nursing Club at their regular meeting held on March 17, 1932, at the Receiving Hospital, Detroit. A large number were present, and at the close of the business meeting the members were shown through the Psychopathic Wards and other interesting departments. Refreshments were served before returning to Windsor by way of the tunnel. Miss Emily McLaughlin, Essex County Sanitarium was hostess to the Club for their regular meeting on April 15, 1932. The members were entertained at bridge followed by supper. The May meeting was to be held at the home of Mrs. (Dr.) Brown, Walkerville.

Correction—On page 266 of the May number of the journal, in the News Notes from the Children's Memorial Hospital, Montreal, the name Miss Frances Eaton, Registrar, Montreal Graduate Nurses' Association should have read Miss Frances Upton, Registrar, Association of Registered Nurses of the Province of Quebec.

VICTORIAN ORDER OF NURSES FOR CANADA

Miss Elizabeth Smellie, Chief Superintendent, was a speaker at the Mother's Day Festival, arranged by the Child Welfare Council of Toronto held at the King Edward Hotel on May 9th.

The annual meeting of the Order was held at the Chateau Laurier, Ottawa, on May 11th and 12th.

At meetings of the Ontario Medical Association held at Milton, St. Thomas and Goderich during April and May, a demonstration of the work of the Order throughout Canada was given by Miss Muriel Winter, Toronto Branch.

TORONTO BRANCH: During Eaton's Baby Week, demonstrations of the care of the baby were given morning and afternoon in the Infant Wear Department at the store, by groups arranged through the Child Welfare Council. Miss Vera Allen, Miss Grace Milne and Miss Lougheed gave the demonstration on afternoons during the week. Miss Jean Derby, who is on extended sick leave and has been at her home in Durham, Ont., is now a patient in St. Johns Hospital. Miss Louisa Reid who has been ill the past few weeks is now at Preston Springs. At the annual meeting of the Staff Council held on May 4th Miss Eva Bayne was re-elected President, Miss Winter and Miss Rogers Vice-Presidents, Miss Lougheed Secretary, and Miss Stevenson, Treasurer.

BIRTHS, MARRIAGES AND DEATHS

BIRTHS

BANNERMAN — Recently, at Hanover, N.H., to Mr. and Mrs. H. W. Bannerman (Harriet MacIntosh, Hospital for Sick Children, Toronto, 1927), a daughter.

BLAIR—On March 2, 1932, at Edmonton, Alta., to Mr. and Mrs. T. Blair (Edythe McTavish, Medicine Hat Hospital, 1929), a daughter, Jessie Margaret.

CHRISTENSEN—On February 24, 1932, at Edmonton, Alta., to Mr. and Mrs. C. P. Christensen (Edna Stevenson, Royal Alexandra Hospital, 1920), a daughter, Vera Mae.

HEFFERING—Recently, at White Plains, N.Y., to Dr. and Mrs. R. Heffering (Louise Downs, Hospital for Sick Children, Toronto, 1926), a son.

KERR—Recently, at Toronto, to Dr. and Mrs. W. J. Kerr (Mabel Martin, Hospital for Sick Children, Toronto, 1924), a son.

KNOWLES—On April 8, 1932, at Ottawa, to Mr. and Mrs. George Knowles (Gladys Winters, Ottawa Civic Hospital, 1929), a daughter.

McADAM—On April 21, 1932, at Ottawa, to Mr. and Mrs. J. M. McAdam (Laura Wright, St. Luke's General Hospital, Ottawa), a daughter.

SUTHERLAND—On February 4, 1932, at Woodstock, Ont., to Mr. and Mrs. Burns Sutherland (Anne Schoffield, Woodstock General Hospital, 1925), a daughter, Margaret Jean.

TILSON—On March 10, 1932, to Mr. and Mrs. Carman E. Tilson (F. Enid Stevenson, Hamilton General Hospital, 1926), a son.

WILLIAMS—On April 6, 1932, at Toronto, to Mr. and Mrs. Russell H. Williams (Elsie M. Sleeman, Grace Hospital, Toronto, 1922), a son.

MARRIAGES

BANNERMAN — MUMBERSON — On April 16, 1932, at New Towell, Betty Mumberson (Collingwood General and Marine Hospital, 1931), to Horace Bannerman, of Stayner.

BROWN—MacINTOSH—On February 9, 1932, at Toronto, Ont., Jean MacIntosh (Hospital for Sick Children, Toronto, 1927) to Donald Brown.

BURKHARDT—ROBERTS—On March 15, 1932, at Indianapolis, U.S.A., Evelyn Roberts (St. John's Hospital, Toronto, 1930) to Dr. Boyd A. Burkhardt, of Clifton, Indiana.

COOMBS — PIERSON — Recently, at Toronto, Eva Pierson (St. John's Hospital, Toronto, 1925) to A. Coombs, of Toronto.

CUNNINGHAM—McHUGH — On March 28, 1932, at Woodslee, Ont., Margaret McHugh (Hotel Dieu Hospital, Windsor, Ont., 1927) to Harold Cunningham, of Detroit, Michigan.

FRASER—OVEREND—On April 20, 1932, Effie M. Overend (Winnipeg General Hospital, 1917) to Donald D. Fraser. At home, Quesnel, B.C.

GILROY—JOHNSTON — On March, 23 1932, at Kemptville, Ont., Hilda Johnston (Oshawa General Hospital, 1921), to Chester Gilroy.

GREEN—BIGGAR—Recently, Alice Biggar (St. John's Hospital, Toronto, 1930) to Harold Green, of Blind River, Ont.

HOGARTH—SHERMAN—On March 30, 1932, at Owen Sound, Ont., Mary E. Sherman (Owen Sound General and Marine Hospital, 1929) to Gordon Hogarth.

KEITH—ELEANOR—On April 4, 1932, at London, England, Grace Eleanor (Hospital for Sick Children, Toronto, 1925) to Dr. William Keith.

LYONS—McKEE—On April 9, 1932, Elva Anna Mae McKee (Lamont Public Hospital, Lamont, Alta., 1925) to William George Lyons, of Toronto.

MacRAE—BURGESS—On March 19, 1932, at Toronto, Ont., Frances Jean Campbell Burgess (Grace Hospital, Toronto, 1930) to Farquhar John MacRae, of Toronto.

THOMPSON—BURRELL—On April 16, 1932, at Caledon East, Ont., Helen Burrell (Grace Hospital, Toronto, 1931) to William Thornley Thompson, Toronto.

THURSTON—CORNISH—On February 6, 1932, at Kendal, Ont., Lenora P. Cornish (Oshawa General Hospital, 1931) to Wallace D. Thurston, of Bobcaygeon, Ont.

WOODS—MYERS—On April 30, 1932, at Westport, Ont., Vera M. Myers (Ottawa Civic Hospital, 1926) to Duncan Woods, Phm.B., of Ottawa.

DEATHS

AUGER—On May 2, 1932, at Medicine Hat, Edna Mabel Auger, R.R.C., Medicine Hat General Hospital, 1906.

INTERNATIONAL HOSPITAL ASSOCIATION

A Post Graduate Course on Hospital Technique is being arranged by the International Hospital Association, with headquarters at the Municipal and University Hospital, Frankfort. The date is September 29th to October 8, 1932.

Applications for enrolment should be sent before July 1, 1932, to Geheimrat Dr. Alter, 5 Moorenstrafe, Dusseldorf, Germany.

The programme includes discussion of hospital administration in its various phases. Miss C. Reimann, Secretary, International Council of Nurses, will discuss The Recruiting of Nursing Staff, and Examinations to Determine its Aptitude. The course will consist of lectures lasting not more than forty-five minutes, demonstrations, visits and discussions.

Contributors to the News Notes Section are requested to keep in mind that the closing date on which contributions can be received at 511 Boyd Building, Winnipeg, Manitoba, and be assured publication in ensuing issue is the twelfth of each month.—Editor.

THE CANADIAN NURSE

The official organ of the Canadian Nurses Association, owners, editors and managers. Published monthly at the National Office, Canadian Nurses Association. 511 Boyd Building, Winnipeg, Man.

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Subscriptions $2.00 a year; single copies 20 cents. Combined annual subscription with The American Journal of Nursing $4.75. All cheques or money orders to be made payable to The Canadian Nurse. Changes of address should reach the office by the 20th of each month. In sending in changes of address, both the new and old address should be given. News items should be received at the office by the 12th of each month. Advertising rates and data furnished on request. All correspondence to be addressed to 511 Boyd Building, Winnipeg, Man.

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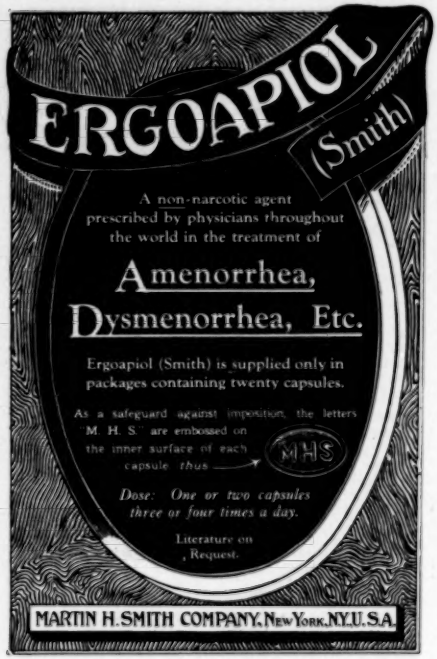
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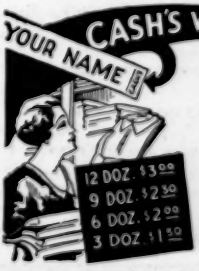

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